MEDICAL SCHEMES ACCOUNTING GUIDE

FOR THE YEAR END 31 DECEMBER 2017

With suggested amendments and comments for the year end 31 December 2017

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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 of 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.

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.
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 members of the scheme own the scheme. However, this excludes healthcare insurance products provided by a long-term and/or short-term insurer registered in terms of the Long-term Insurance Act 52 of 1998 and/or the Short-term Insurance Act 53 of 1998.

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:

   • Failure to pay, within the time allowed in the medical scheme’s rules, the membership contributions required;
   • Failure to repay any debt due to the medical scheme;
   • Death of member;
   • Committing any fraudulent act;
   • Prior termination of the contract, in terms of the rules, by either party;
   • Non-disclosure of material information; and
   • 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. Medical schemes set prices that fully reflect the risk at a scheme level (after taking into account investment income). These risks are managed in different portfolios of members (i.e. benefit options) 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 portfolio 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:

- Any emergency medical condition;
- A limited set of approximately 270 medical conditions; and
- 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 in respect of a member 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). The constitutional court judgment in the matter between Genesis Medical Scheme and the Registrar of Medical Schemes and the Council For Medical Schemes (the judgement) decided 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 judgement 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.

13. 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.

14. 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.

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

**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.

**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.

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

**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 under 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** – means 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 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.

**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 bank accounts and on arrear balances), dividends, rental and policy income as well as net realised gains or losses on available-for-sale financial assets 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 programmes.

**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 “solvent 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 recoveries for claims relating to risk transfer arrangements.

**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 related services.

**Personal medical savings accounts (PMSA)** – means the balance of allocated savings contributions available for the exclusive benefit of the member and his or her dependants 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 personal medical savings account liability on the statement of financial position.

\(^1\) Long-term Insurance Act No. 52 of 1998
**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 either an insurer registered as a long-term insurer in terms of the Long-term Insurance Act No. 52 of 1998 or as a short-term insurer in terms of the Short-term Insurance Act No. 53 of 1998 and that is entitled to engage in the practice of reinsurance.

**Relevant healthcare expenditure** – represents net claims incurred and net income/ (expense) on risk transfer arrangements.

**Relevant health service** – 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.

**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.

**Report of the Board of Trustees** – is the report by those persons with a fiduciary responsibility towards a medical scheme. 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.

**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 savings 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.

**Savings 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.

**Savings claims** – means healthcare benefits paid from members’ personal medical savings accounts in terms of the scheme’s registered rules and Regulation 10 of the Act.
LEGISLATION

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

1. The following two definitions, amongst others, are contained in the Act:

   “Business of a medical scheme means the business of undertaking liability in return for a premium or contribution –
   
   (a) To make provision for the obtaining of any relevant health service;
   
   (b) To grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
   
   (c) 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.”

   “Relevant health service means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object –
   
   (a) The physical or mental examination of that person;
   
   (b) The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
   
   (c) The giving of advice in relation to such defect, illness or deficiency;
   
   (d) The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
   
   (e) The prescribing or supplying of any medicine, appliance or apparatus in relation to such defect, illness or deficiency or pregnancy, including the termination thereof; or
   
   (f) 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 practised, 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.”

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:
(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)

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<th>Break LESS than 90 days (0 to 89 days)</th>
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<td>Regardless of previous membership</td>
<td>24 Months and longer</td>
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<td>▪ General waiting period – 3 Months</td>
<td>▪ General waiting period – 3 months</td>
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<td>▪ Condition specific – 12 months</td>
<td>▪ Waiting period does not apply to PMB’s</td>
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<td>▪ Waiting period applies to PMB’s</td>
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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):

- A 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
medical scheme, any administrator, and any person associated with any of the above mentioned (section 35(8)).

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

(c) The annual financial statements, i.e. the financial documentation and information to be submitted 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 Trustees to the Registrar by 30 April each year;
- Section 37(2) specifies what statements/reports are considered to form part of the annual financial statements;
- Sections 37(4) and (5) detail the requirements in respect of the accounting framework and further information that needs to be included in the annual financial statements; and
- The disclosure of financial information in respect of every benefit option offered by the medical scheme is required in terms of section 37(4) (d). This is required to be audited in terms of Circular 4 of 2008.

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 schemes.

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 sets out the duties of the Board of Trustees, which are significant, 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 enrols in another medical scheme without a personal medical savings account provision or selects a benefit option without a personal medical savings account; and
   (d) Regulation 10(6) stipulates that personal medical savings account facilities may not be utilised to provide for benefits and co-payments that relate to PMBs.

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.

**Income Tax Act 58 of 1962, as amended**

36. 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**

37. 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:

- 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)
- 6/2017: Categorisation of assets in terms of Annexure B to the Regulations
- 2/2017: Adjustment of fees payable to brokers with effect from 1 January 2017
- 49/2016: Prescribed auditor report templates
- 35/2016: General concerns noted during the analysis of the 2015 Annual Financial Statements (AFS)
- 31/2016: Standards for authorisation of auditors
- 9/2016: Adjustment of fees payable to brokers with effect from 1 January 2016
- 8/2016: Categorisation of assets in terms of Annexure B to the Regulations
- 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 Statements and Statutory Returns
• 21/2015: Adjustment to fees payable to Brokers with effect from 1 March 2015
• 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
• 23/2012: Explanatory Note 2 of Annexure B
• 44/2011: Revised Managed Care Standards
• 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
• 25/2007: Auditor approval applications
• 41/2006: 2006 audited financial statements:
  • Reporting of non-compliance
• 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

38. 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; 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 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 AFS are distributed to members is dealt with in the scheme’s rules. Scheme rules further prescribe the format of the AFS to be distributed. The format of the AFS distributed to members generally takes one of three forms:
   - Full set of AFS;
   - Summarised set of AFS; or
   - Highlights document.

5. As per Section 37(4) the full set of AFS needs to be prepared in accordance with IFRS; and in the manner required by the Act. The AFS needs to be audited in terms of Section 37(3).

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 AFS.
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 AFS.

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

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*, issued by CMS, for the prescribed format of the statement of comprehensive income.

**Statement of financial position**

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

**Statement of changes in funds and reserves**

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

**Statement of cash flows**

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

**The impact of IFRS 10 Consolidated Financial Statements**

14. The impact of IFRS 10 *Consolidated Financial Statements* together with the impact of IFRS 3 *Business Combinations*, should be discussed with the scheme’s auditors, when it has entered into a business combination. 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 sections *the impact of IFRS 12 Disclosure of interests in other entities* and Appendix II of this Guide.

The following table provides a summary of the possible impact of IFRS 10 on medical schemes, which needs to be assessed:
<table>
<thead>
<tr>
<th>IFRS Standard</th>
<th>Details</th>
<th>Impact</th>
</tr>
</thead>
</table>
| IFRS 10 <br>Consolidated Financial Statements | • IFRS 10 defines the principle of control and establishes control as the basis for determining which entities are to be consolidated.  
• IFRS 10 also sets out the accounting requirements for the preparation of consolidated financial statements.  
• IFRS 10 paragraph 7 states that an investor controls an investee if the investor has all of the three elements of control:  
  1. **Power** over the investee;  
  2. Exposure or rights to variable returns from involvement with the investee; and  
  3. The ability to use power over the investee to affect the amount of the investor’s returns.  
• IFRS 10 states that for an investor to have power over the investee it must have existing rights that give it the current ability to direct the relevant activities of the investee.  
• In assessing power, only substantive rights and not protective rights are considered. | • Medical schemes’ investments may result in control over the investees, which would require medical schemes to consolidate those entities in their financial statements.  
• Medical schemes’ rights in investees are generally protective (i.e. rights designed to protect the interests of the investor) and IFRS 10 states that an investor that holds only protective rights cannot have power over an investee.  
• Even though in most instances it is expected that medical schemes’ rights would be protective, the investments would need to be evaluated to ensure no other elements of control are met that require consolidation of those entities.  
• The investments 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). |

The impact of IFRS 3 *Business Combinations*

15. 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*

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

17. The acquisition method involves the following steps:
   • Identifying the acquirer (being the entity that obtains control (as defined in IFRS 10 – refer paragraph 15. above) of another entity);
• 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).

18. 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.”

19. 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.

20. 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.

21. 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

22. 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 acquirers member interests instead of the acquisition-date fair value of the acquirer’s member interests transferred as consideration.

23. In addition, the acquirer in a combination of mutual entities shall recognise the acquires 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.
24. 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**

25. 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**

26. 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.

27. In this example, medical scheme A is identified as the acquirer. It has control over the amalgamated scheme through its current trustees.

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

29. 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.

30. 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**

31. 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 on the recognition and measurement of insurance contracts. IFRS 4 was amended in 2016.
to allow entities the option to apply the deferral approach or overlay approach on IFRS 9. Under the deferral approach, some entities whose activities are predominantly connected with insurance, can defer the application of IFRS 9 to the earlier of the application of IFRS 17 or 1 January 2021. The overlay approach is available to all issuers of insurance contracts, and it enables entities to remove from profit or loss additional volatility that may arise if IFRS 9 is applied with IFRS 4. IFRS 17 replaces IFRS 4 and becomes effective for annual periods beginning on or after 1 January 2021 and 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. Members are advised to start engaging in discussions on how to prepare for the implementation of IFRS 17.

The definition of an insurance contract

32. IFRS 4 is applicable to all issuers of insurance contracts.

33. 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.

34. 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.

35. A reinsurance contract is defined by IFRS 4 as an insurance contract issued by one insurer (the reinsurer) to compensate another insurer (the cedent) for losses on one or more contracts issued by the cedent.

36. 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.
37. 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.

38. 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.

**Example: Definition of an insurance contract**

**Background**

ABC Medical Scheme provides in-hospital benefits to a member for a fixed monthly contribution. The contract covers all costs incurred by the member while he is in hospital up to an overall annual limit. The risk that the member will visit a hospital during the contract period is a commercially viable risk. Does this contract meet the definition of an insurance contract?

**Suggested solution**

IFRS 4 defines an insurance contract as:

“A contract under which one party (the insurer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder”.

The classification process is as follows:

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Identify the insured event.</td>
<td>The insured event is costs incurred by the member while he is in hospital.</td>
</tr>
<tr>
<td>(b) Establish if the insured event affects the insured adversely.</td>
<td>The insured event will affect the member adversely as he will have to pay the costs incurred.</td>
</tr>
<tr>
<td>(c) Identify the scenario in which the insured event occurs.</td>
<td>The costs can be incurred at any stage within the term of the contract.</td>
</tr>
<tr>
<td>(d) Establish if (c) has commercial substance (i.e. does it have a discernible effect on the economics of the transaction).</td>
<td>Yes, the scenario in (c) does have commercial substance as the risk that the member will visit a hospital during the contract period is a commercially viable risk (i.e. it is the reason why the member entered into the contract).</td>
</tr>
<tr>
<td>(e) Determine the amount payable by the insurer under (c).</td>
<td>The amount payable under the scenario in (c) is the costs incurred by the member while in hospital up to an overall annual limit.</td>
</tr>
<tr>
<td>(f) Determine another scenario in which the insured event does not occur.</td>
<td>The contract expires without any insured event happening.</td>
</tr>
<tr>
<td>(g) Establish if (f) also has commercial substance (i.e. does it have a discernible effect on the economics of the)</td>
<td>Yes, the scenario in (f) does have commercial substance; otherwise ABC Medical Scheme could not offer the benefits in a manner that is</td>
</tr>
<tr>
<td>transaction?</td>
<td>commercially viable for it; i.e., it is commercially viable that the member would not claim over the contract period.</td>
</tr>
</tbody>
</table>
Consideration | Application
--- | ---
(h) Determine the amount payable by the insurer under (g). | The amount payable under the scenario in (g) is nil.
(i) Establish if (e) is significantly more than (h). | The amount payable under (e) is significantly more than (h) as the amount payable under (h) is nil.
(j) If yes, then the contract is an insurance contract. | Therefore, the contract is an insurance contract.

**Deposit components**

39. 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.

40. The scheme applies IFRS 4 to the insurance component of the medical benefit plan or contract, and IAS 39 *Financial Instruments: Recognition and Measurement* 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.

**Liability adequacy test**

41. 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).

42. 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 risk 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 risk claims provision.
43. Contracts that are subject to broadly similar risks that are managed together as a single portfolio may be aggregated in applying the LAT.

44. 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.

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

**Sensitivity analysis**

46. 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**

47. 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.

48. 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.
49. The main disclosures in the Implementation Guidance to IFRS 4 as a result of IFRS 7 can be summarised as follows:

<table>
<thead>
<tr>
<th>IG45</th>
<th>When determining the broad classes for which separate disclosure is required, a scheme might consider <strong>how best</strong> to indicate the level of uncertainty associated with the risks underwritten.</th>
</tr>
</thead>
</table>
| IG48 | Disclosures are required about the **objectives, policies and processes** followed in managing the risks from insurance contracts.  
Among others, disclosure has to be provided about –  
• 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 | 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.  
Among others, these disclosures may include the following:  
• 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. 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 and insurance contracts

50. IFRS 7 Financial Instruments: Disclosures was applied by medical schemes for the first time for the year ended 31 December 2007. Refer below for details of the impact of IFRS 7 on medical schemes. Refer to Appendix II for illustrative disclosures.

51. IFRS 7 deals with the disclosure requirements in relation to all risks arising from financial instruments, whether recognised or not, and 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.

52. 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 disclosures); and
   - The approach taken in managing those risks (qualitative disclosures).

53. Diagrammatically IFRS 7 can be summarised as follows:
54. 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.

**Categories vs classes**

55. 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 are those 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.

56. 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 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.

57. 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).

58. 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 judgement in determining the appropriate level of detail to be disclosed to comply with the IFRS 7 requirements.
59. IFRS 7 requires disclosure of the following items by class:

- Financial assets not qualifying for de-recognition;
- The reconciliation of an allowance account;
- The amount of impairment loss for financial assets;
- Fair values; and
- Specific disclosures relating to financial risk.

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

60. 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

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

- The carrying amounts of financial assets and financial liabilities under each of the categories in IAS 39. In the case of financial assets and liabilities at fair value through profit or loss, the carrying amount must be disclosed separately for instruments designated upon initial recognition and those that meet the definition of held for trading.

- IFRS 7.9 provides the disclosure requirements if a scheme has designated a loan and receivable (or group of loans and receivables) at fair value through profit or loss. The disclosures prescribed by IFRS 7.9 apply only to those loans and receivables designated at fair value through profit or loss and do not apply to all loans and receivables or to all assets designated as fair value through profit or loss. For example, a listed bond is not classified as “loans and receivables” as it is quoted. Therefore, in this case the disclosure per paragraph 9 is not required if the bond is designated.

- Where financial liabilities have been designated at fair value through profit or loss, the disclosure requirements as per IFRS 7.10 should be provided. A scheme is required to disclose the amount of change in a liability's fair value that is attributable to changes in the liability’s credit risk. A method provided in the standard to compute the amount to be disclosed assumes that the only relevant change in market condition for the liability is a change in the observed benchmark interest rate.

- The methods used to comply with IFRS 7.9-10 must be disclosed as required by IFRS 7.11.
• If a financial asset measured at amortised cost has been reclassified as at fair value, or vice versa, the amount and reason for reclassification have to be disclosed. If a scheme has taken advantage of the amendment to IAS 39 issued in October 2008 and has reclassified a financial asset out of fair value through profit or loss category or out of the available-for-sale category the disclosure required by IFRS 7.12A 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.

• 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 paragraph 15 of IFRS 7.

• When financial assets are impaired and the scheme records the impairment (i.e. credit losses) in a separate account (i.e. an allowance account), a scheme shall disclose a reconciliation of changes in that account during the period for each class of financial asset.

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

• 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 loans 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 and reserves**

62. The following shall be disclosed either on the face of the statement of comprehensive income or in the notes thereto:

• Net gains or net losses on the various categories of financial instruments. 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 the appendix to IFRS 7, 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;
• Total interest income and total interest expense (calculated using the effective interest method) for financial assets that are measured at amortised cost or financial liabilities that are not at fair value through profit or loss;

• 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;

• Interest income on impaired financial assets; and

• The amount of any impairment loss for each class of financial asset. This disclosure may already be provided as part of the disclosure of the reconciliation of allowance account for credit losses referred to above. A scheme should also disclose the criteria used to establish whether an impairment loss has occurred.

Other disclosures

63. 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 22 to 24 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 manner similar to that of the carrying amounts.

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 paragraph 29 of IFRS 7, which exempts fair value disclosure under certain conditions.

Nature and extent of risks arising from financial instruments

64. 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

65. For each type of risk arising from financial instruments, a scheme shall disclose the requirements of IFRS 7, paragraph 33, IG 15-17.

Quantitative disclosures

66. For each type of risk arising from financial instruments, a scheme shall disclose the requirements of IFRS 7, paragraph 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 judgement, taking into account the scheme’s circumstances. IFRS 7, Appendix B, paragraph 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

67. A scheme shall disclose the following:

- The requirements of IFRS 7.36 by class of financial instruments (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.

- Information about the credit quality of financial assets that are neither past due nor impaired. Additional information on the credit quality that could be disclosed is provided in IFRS 7 paragraphs IG 23 – 25.

- Information by class of financial asset either past due or impaired;

- Disclosure required for assets obtained by taking possession of collateral held by the scheme and other credit enhancements called upon.
Diagrammatically the credit risk disclosure can be summarised as follows:

<table>
<thead>
<tr>
<th>Fully performing</th>
<th>Past due</th>
<th>Impaired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying amount</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of collateral held</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit quality</td>
<td>Age analysis</td>
<td>Analysis of individually impaired financial assets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reconciliation of allowance account</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Possessed collateral</td>
</tr>
</tbody>
</table>

**Liquidity risk**

68. 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**

69. 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**

70. 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. Refer to paragraph 135 of IAS 1 for more information.

**Transfers of financial assets**

71. Paragraphs 42A to 42H of IFRS 7 include disclosure requirements that a scheme should provide for financial assets that have been transferred, which are either derecognised in their entirety or not derecognised in their entirety.
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 paragraph 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 paragraphs 42E to 42G should be provided.

**The impact of IFRS 8 Operating Segments**

72. This standard requires an entity to adopt the “management approach” to reporting on the financial performance of its operating segments. The Standard sets out requirements for disclosure of information about an entity’s operating segments and also about the entity’s products and services, the geographical areas in which it operates, and its major customers. The disclosure should enable users of its financial statements to evaluate the nature and financial effects of the business activities in which it engages and the economic environments in which it operates. IFRS 8 applies to the separate or individual financial statements of an entity and to the consolidated financial statements of a group with a parent:

- Whose debt or equity instruments are traded in a public market; or
- That is in the process of filing its financial statements with a securities commission or other regulatory organisation for the purpose of issuing any class of instruments in a public market.

Medical schemes are therefore excluded from the reporting requirements set out in IFRS 8.

**The impact of IFRS 9 Financial Instruments**

73. 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*

74. 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.

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 per cent; 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 2021.

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.

75. 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 assets, the instrument is not separated, instead the entire hybrid as a whole is assessed for classification.

76. IFRS 9 now 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)

77. 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.

78. IFRS 9 requires financial assets to be reclassified between measurement categories when, and only when, the entity’s business model for managing them changes. 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. Financial liabilities are not reclassified.

**Impairment**

79. IFRS 9 has a single impairment model that applies to all financial instruments within the scope. Under the IFRS 9 impairment model, expected credit losses are measured as either 12-month expected credit losses or lifetime expected credit losses. 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

80. 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 at all times.

**Hedge accounting**

81. 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**

82. IFRS 9 introduces new presentation requirements and extensive new disclosure requirements.

**The impact of IFRS 12 Disclosure of interests in other entities**

83. 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 money market portfolio investments. (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.

84. 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.
85. To the extent that Schemes have subsidiaries, joint arrangements or associates, Schemes should disclose significant judgements 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**

86. 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**

87. If the Medical Scheme has any interests in unconsolidated structured entities, 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**

88. 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**

89. 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 paragraph 9).

**Fair value principles**

90. 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 or restrictions on an asset’s sale or use (IFRS 13 paragraph 11).

91. 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 paragraph 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).

92. 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 paragraph 16).

93. 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 paragraph 22).

94. 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 paragraph 27 and Appendix A).
Financial liability with a demand feature

95. 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 paragraph 47).

Valuation techniques

96. 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 paragraph 61).

97. 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 paragraph 62).

98. Three widely used valuation techniques are (IFRS 13 paragraph 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 paragraph 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” (IFRS 13 paragraph 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 paragraph B10).

Inputs based on bid and ask prices

99. 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 paragraph 70).

100. 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 paragraph 71).

Disclosure objective

101. 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 paragraph 91).

**Recurring vs non-recurring**

102. 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**

103. 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 paragraph 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 paragraph 81).
- Level 3 inputs are unobservable inputs for the fair value measurement of an asset or a liability (IFRS 13 paragraph 86).
The diagram below outlines the approach to determine the classification of fair value measurements in the fair value hierarchy:

**Specific disclosures required**

105. 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 paragraph 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 paragraph 93(g));
• For recurring fair value measurements categorised within Level 3 of the fair value hierarchy (IFRS 13 paragraph 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 paragraph 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.
* in the list above indicates that the disclosure is also applicable to a class of assets or liabilities which is not measured at fair value in the statement of financial position but for which the fair value is disclosed (IFRS 13 paragraph 97).

**The impact of IAS 38 Intangible Assets**

106. 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 paragraph 69).

107. 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 paragraph 69A).

108. 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 paragraph 70).

**Contribution income**

109. Contributions are recognised in the accounting period to which the related risks refer and should be in line with the rules of the medical scheme. 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.

110. 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. Savings contributions are disclosed separately as a deduction from gross contributions. This is shown in the notes to the financial statements as the savings contributions do not meet the definition of income for the medical scheme, but are deposits received from members. Net 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.

111. 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.
112. 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**

**Recognition of claims**

113. 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).

114. The medical scheme should determine whether its claims liabilities (IBNR and/or claims creditor) recognised (based on service delivery) are less than the amount that would be required if the relevant liabilities were within the scope of IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*.

115. The medical scheme should therefore consider whether an onerous contract (i.e. member’s contract with the scheme) exists at the reporting date. If the contract is onerous, an additional liability should be recognised.

**Net risk claims incurred**

116. When accounting for claims, a medical scheme recognises the total estimated cost, net of discounts, third party recoveries and recoveries from members for co-payments and personal medical savings accounts, of settling all claims arising from healthcare costs that have been incurred in the period in terms of the scheme’s registered rules, 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.

117. 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. When amalgamations occur the medical schemes should amalgamate the results from the date of amalgamation. Claims relating to the run-off period will form part of the IBNR.

118. With reference to paragraphs 116 and 117 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;
- Movement in the provision for outstanding claims;
- Own facility cost for services to members using own facilities (refer to paragraphs 138 - 143);
- Claims settled in terms of risk transfer arrangements (refer to paragraphs 110 – 113); and
• Charges for accredited managed healthcare services (excluding risk transfer arrangements).

119. All accreditable 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.”

120. Recoveries under risk transfer arrangements should not be netted off against claims incurred, but should be recorded under the income and expenses from risk transfer arrangements. The following are Gross claims – current year registered benefits;

• Services provided to members in own facilities;
• Movement in provision for outstanding claims for the year;
• Accredited managed healthcare services;
• Savings claims paid and reported; and
• Third party recoveries.

Net income/ (expense) on risk transfer arrangements

121. Income and expenses that relate to risk transfer arrangements are disclosed separately in the statement of comprehensive income.

122. 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.

123. Medical scheme membership issued by the medical scheme to members exposes the medical scheme to losses (i.e. claims from members) under those contracts. Where the medical scheme enters into a capitation agreement with a supplier (e.g. a hospital group) to provide medical services to a pre-determined member group or to compensate the medical scheme for losses on those contracts or to mitigate those losses, the medical scheme effectively enters into a risk transfer arrangement.

124. 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

Journal 1 – Recognition of total capitation fee paid

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.

A would account for the capitation fee as follows:

<table>
<thead>
<tr>
<th>Dr. Capitation fee (I/S)</th>
<th>Cr. Bank (B/S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 000</td>
<td>50 000</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Dr. Claims (I/S) [Value of the claims incurred from members]</th>
<th>Cr. Claims recoveries (I/S) [Capitation claims recovered from B]</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 000</td>
<td>70 000</td>
</tr>
</tbody>
</table>

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 (I/S) 8 000
Cr. IBNR liability (B/S) 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 (B/S) 8 000
Cr. Recovery under risk transfer arrangements (I/S) 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 (I/S) 2 000
Cr. IBNR Provision (B/S) 2 000

Dr. Recovery under risk transfer arrangements (B/S) 2 000
Cr. Recovery under risk transfer arrangements (I/S) 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 (B/S) 10 000
Cr. Recovery under risk transfer arrangements (B/S) 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:
<table>
<thead>
<tr>
<th>Outstanding Risk Claims provision</th>
<th>20XX+1(after year end)</th>
<th>20XX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance</td>
<td>8000</td>
<td>XXX</td>
</tr>
<tr>
<td>Changes to estimates recognised in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>2000</td>
<td>XXX</td>
</tr>
<tr>
<td>Claims Settled</td>
<td>(10000)</td>
<td>XXX</td>
</tr>
<tr>
<td>Claims Raised</td>
<td>XXX</td>
<td>8000</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>XXX</td>
<td>8000</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Claims Incurred</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Paid By Scheme</td>
<td></td>
<td>XXX</td>
</tr>
<tr>
<td>Claims Settled</td>
<td></td>
<td>70 000</td>
</tr>
<tr>
<td>Outstanding Risk Claims Provision</td>
<td></td>
<td>8000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant transfer agreements (Capitation Agreement)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums/Fees paid</td>
<td></td>
<td>50000</td>
</tr>
<tr>
<td>Claims Settled/Recoveries</td>
<td></td>
<td>(70 000)</td>
</tr>
<tr>
<td>Outstanding risk claims provision – Recoveries</td>
<td></td>
<td>(8000)</td>
</tr>
</tbody>
</table>

| Relevant healthcare expenditure                |                         |      |

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

**Outstanding claims provision**

125. 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 42. to 46. of this guide for further details on the LAT.)
Trade and other payables (including claims reported not yet paid – accrual)

126. 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.

Commercial reinsurance

127. 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

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

128. 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. Brokers’ 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

129. 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

130. 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. Consider disclosure for the following costs incurred in the administration of a medical scheme:

- Fees and disbursements paid or payable to a third party medical scheme administrator for the administration of the medical scheme;
Other contracted services that are not of a claims nature or managed care: management 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 92).

131. 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.

132. 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.

Administrative expenditure: benefit management services

133. 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.

134. 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.

135. 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 efficacy or effectiveness.

136. 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).

137. These services are included in non-healthcare expenditure, as part of administration expenditure: benefit management services.

**Own facility surplus or deficit**

138. Medical schemes are expanding their operations to 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. Where medical schemes make these facilities available to third parties they receive an income for services rendered.

139. Income arising from making the medical scheme’s own facilities available to render services to third parties is recognised on an accrual basis as the services are rendered. Income from services rendered to third parties in own facilities should be reflected under “other income”.

140. 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.

141. 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).

142. Benefits (services) rendered by the own facility to the medical scheme’s members are included in claims incurred as proportional share of costs incurred.

143. The own facility surplus or deficit therefore represents the net result for services provided to third parties.

**Grants**

144. Where the medical scheme receives a grant from a sponsor, 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

145. 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.

146. 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.

147. It should be considered further whether the underlying assets are classified as at fair value through profit or loss or available-for-sale. For assets classified “at fair value through profit or loss”, the interest, dividends and fair value movements are recognised in profit or loss. 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 paragraph 55(b)).

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

148. The definition of “linked policy” as included in section 1 of the Long-term Insurance Act, 1998 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
include interest and dividends. The definition goes further to describe the value of the assets to 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”.

149. 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 (refer paragraph 102. of this guide). Interest and dividends earned on the underlying investments accrue to the 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**

150. 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.

151. 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.

152. 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.

153. Any advances on savings contributions are funded from the scheme’s funds, and the risk of impairment is carried by the scheme.

154. 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.

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

156. The personal medical savings account liability mainly comprises savings contributions which are a deposit component of the insurance contracts. IFRS 4 allows, but does not require, the medical scheme to unbundle this deposit component. It is practice within the medical schemes industry to unbundle the deposit component and measure it separately in terms of IAS 39 because the personal medical savings accounts are managed separately. The remaining insurance component of the contract is recognised in accordance with IFRS 4, as discussed in this guide.
157. The deposit component meets the definition of a financial liability. In terms of IAS 39, 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.

158. This guide does not consider the treatment of embedded derivatives. Should schemes identify an embedded derivative within a contract, they should apply IAS 39.

**Offsetting and Reclassification**

159. IAS 1 paragraphs 32 to 35 do 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**

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

161. 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?**

162. Each medical scheme needs to assess individually who its related parties are, taking into account its individual circumstances.

163. 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 pf which it is a part, provides key
management personnel services to the reporting entity or to the parent of the
reporting entity.”

164. 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.

<table>
<thead>
<tr>
<th>Party</th>
<th>IAS 24.9</th>
<th>Other considerations</th>
</tr>
</thead>
</table>
| 1. Employer/ Employer groups | Consider part (b) (v) of the definition | IAS 24.9 part (b) of the definition of a Related Party states that “An entity is related to a reporting entity if any of the following conditions applies:
(v) The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.”
Consider the definition in the following circumstances:
Closed scheme – Sponsoring employer is probably related consider definition
Open scheme – employers not likely to be related. |
| 2. Trustees | Consider part (a) (iii) of the Definition | IAS 24.9 part (a) of the definition of a Related Party states that “A person or a close member of that person's family is related to a reporting entity if that person:
(iii) is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.”
"Key management personnel is defined as those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any |
<p>| 3. Principal officer | Consider part (a) (iii) of the Definition | |
| 4. Members of executive committee/ financial managers/ Chief Executive | Consider part (a) (iii) of the definition | |</p>
<table>
<thead>
<tr>
<th>Party</th>
<th>IAS 24.9</th>
<th>Other considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Other key management personnel of the scheme</td>
<td>Consider part (a) (iii) of the definition</td>
<td>director (whether executive or otherwise) of that entity.” (IAS 24.9)</td>
</tr>
<tr>
<td>6. Other persons with significant influence over an entity.</td>
<td>Consider part (a) (ii) of the definition</td>
<td>IAS 24.9 part (a) of the definition of a Related Party states that “A person or a close member of that person’s family is related to a reporting entity if that person: (ii) has significant influence over the reporting entity;”</td>
</tr>
<tr>
<td>7. Close family members of individuals identified in points 2-6 of this table.</td>
<td>Consider part (a) (ii) and (iii) of the definition</td>
<td>Close members of the family of a person are defined as those family members who may be expected to influence, or be influenced by, that person in their dealings with the entity and include: (a) that person's children and spouse or domestic partner; (b) children of that person's spouse or domestic partner; and (c) dependants of that person or that person's spouse or domestic partner. (IAS 24.9) Specifically consider non-dependant family members that are in a related profession (e.g. son of trustee who is a doctor)</td>
</tr>
<tr>
<td>8. Administrators</td>
<td>Consider part (a) (iii) of the definition</td>
<td>A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services. In considering the management entity, the entity’s parent, its subsidiaries and its fellow subsidiaries should be taken into account. Administrators are not automatically related parties of the scheme by mere fact of the function that they perform in relation to the scheme and the service agreement in place. Administrators may not control a scheme (section 57(3) of the Act). IAS 24.11 “In the context of this Standard, the following are not related parties: (d) A customer, supplier, franchisor, distributor or general agent with whom an entity transacts a significant volume of business, is not considered a related party simply by virtue of the resulting economic dependence.” Administrators could, however, form part of the key management of the scheme – consider the following: • Does the administrator have a strong influence</td>
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<tr>
<td>Party</td>
<td>IAS 24.9</td>
<td>Other considerations</td>
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<tr>
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<td></td>
<td></td>
<td>over directing the scheme? Does this translate into participation in the policy decision-making process?</td>
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<td></td>
<td></td>
<td>• Does the administrator provide key management personnel and access to key resources that enable the Board of Trustees to make decisions?</td>
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<td></td>
<td></td>
<td>• Are the trustees effective in directing the scheme, or is there heavy reliance on administrators for guidance and advice?</td>
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<td></td>
<td></td>
<td>• Consider the pricing structure of administrator? Does the administrator charge a fixed fee?</td>
</tr>
<tr>
<td>9. Accredited managed care organisations</td>
<td>Consider part (a)(iii) and (b)(i) to (vi) of the definition</td>
<td>A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services. In considering the management entity, the entity’s parent, its subsidiaries and its fellow subsidiaries should be taken into account. Reference should also be made to IAS24 paragraph 11 (see paragraph 8 above).</td>
</tr>
<tr>
<td>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:</td>
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<tr>
<td></td>
<td>(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).</td>
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<tr>
<td></td>
<td>(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.</td>
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</tr>
<tr>
<td></td>
<td>(iii) One entity is a joint venture of a third entity and the other entity is an associate of the third entity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(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.</td>
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</tr>
<tr>
<td></td>
<td>(v) The entity is controlled or jointly controlled by a person identified in (a).</td>
<td></td>
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<td></td>
<td>Consider:</td>
<td></td>
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<tr>
<td></td>
<td>• Does the scheme have its own accredited managed care organisation?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is the accredited managed care organisation an associate, joint venture or subsidiary of the scheme or its administrator?</td>
<td></td>
</tr>
<tr>
<td>Party</td>
<td>IAS 24.9</td>
<td>Other considerations</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **10. Brokers and investment managers**   | Consider part (a)(ii) and (iii) and (b)(i) to (iv) of the definition     | A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services.  

In considering the management entity, the entity’s parent, its subsidiaries and its fellow subsidiaries should be taken into account.  

Consider:  
- Is the broker or investment manager an associate, joint venture or subsidiary of the scheme or its administrator?  
- Refer to IAS 24.11(d). Is the broker the exclusive or sole broker of the scheme? |
| **11. Post-employment benefit plan**      | Consider part (b)(v) of the definition                                    | This will only be applicable if the scheme has employees of its own.                                                                                                                                                   |
| **12. Trade unions**                     | Consider IAS 24.11                                                       | Trade unions are not necessarily related parties because of their normal dealings with the scheme (IAS 24.11(c)).                                                                                                      |
| **13. State-controlled schemes**         | Consider IAS 24.9 definition of government-related entities             | A government-related entity is defined as an entity that is controlled, jointly controlled or significantly influenced by a government. (IAS 24.9)                                                                    |
| **14. Subsidiaries, associates and joint arrangements of the scheme, including other group entities** | Consider part (b)(i) to (vi) of the definition                           |                                                                                                                                                                                                                     |
| **15. An entity that is:**               | Consider part (b)(vi) of the definition                                 |                                                                                                                                                                                                                     |
|  - Controlled; or                        |                                                                          |                                                                                                                                                                                                                     |
|  - Jointly controlled by any individual in points 2-7 of this table. |                                                                          |                                                                                                                                                                                                                     |
| **16. Other significant parties**        | Consider part a(ii) and (iii) and (b)(i) to (vi) of the definition       |                                                                                                                                                                                                                     |

**What should be disclosed?**

165. 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*
166. 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; 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**

167. In terms of paragraph 17 of IAS 24, 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; and
- Termination benefits.

168. Trustee remuneration is disclosed in a separate note in the financial statements. The related party note may simply make reference to this note.

169. Schemes are reminded that the disclosure requirements as required per section 57 of the Act, read together with Regulation 6A, will also need to be met, which requires the remuneration and other considerations to be disclosed per trustee.

**Other transactions**

170. 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.

171. 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 venturer;
• Key management personnel of the entity; and
• Other related parties.

172. 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.

173. 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. 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

174. A state-controlled scheme is exempt from the disclosure requirements of paragraph .07 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.

175. If a state-controlled scheme applies the exemption in paragraph .11, it shall disclose the following about the transactions and related outstanding balances referred to in paragraph .11:
• 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?

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

177. However, in the context of related party disclosures, size is not of primary importance as IAS 24 paragraph 9 defines a related party transaction as a transfer of resources, services or obligations between related parties, regardless of whether a price is charged. On the basis of this definition, schemes will have to prove that related party disclosures are qualitatively not material in order to make use of IAS 1 paragraph 31. Given the qualitative importance placed on related party disclosures by IAS 24 this may be difficult to do.

178. 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).

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

Guarantees received by the medical scheme from a third party

180. 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.

181. 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

182. 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.

183. 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 surplus was credited/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)

184. 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.

185. 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 paragraph 89 of IAS 37). 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.

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

Surplus/ (deficit) per benefit option

187. 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 surplus/ (deficit) 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 surplus/ (deficit) 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.

188. 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.

Consolidations

189. A medical scheme should prepare consolidated financial statements in terms of IFRS 10 Consolidated Financial Statements, if it has subsidiaries.
190. 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.

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

**Non-compliance matters**

192. 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.

193. 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.

194. 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 \textit{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 Report on Governance for South Africa 2009 (King III) applies and is applicable from 1 March 2011. CMS has indicated that schemes are encouraged, but not obliged, to comply with King III. King III is obtainable from the SAICA website and Institute of Directors and readers are referred to the code 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 (King III) 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. 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
• Corrective course of action adopted to ensure compliance, including the timing of 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 should also state that savings contributions are refundable when a member enrols in another benefit option or another medical scheme without a personal medical savings account, or does not enrol in another medical scheme, and that the accumulated unutilised personal medical savings account balance will be transferred to the member in terms of the medical scheme’s rules. Details of any interest earned on the members’ investment in terms of the rules of the scheme could also be provided.

9. The Board of Trustees’ report is to address the operations of the audit committee and other relevant committees, such as the investment committee, the remuneration committee and the ex gratia committee (as applicable to the medical scheme).
10. In terms of good corporate governance practices, financial statements are to include a 
responsibility statement 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;

- 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:

- 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 an 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

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

1. During the annual financial statement analysis in May 2017, 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 2017 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-compliant 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. The following non-compliance with the provisions of the Act was noted but generally not reported in both the annual financial statements and Board of Trustees’ report. Some of the more common examples are:
   • Section 26(1)(c), (4) and (11) – ancillary products;
   • Section 33(2) – self-supporting benefit options;
   • Section 35(8) – investment in related parties;
   • Section 35(5) read in conjunction with Regulation 30 and Annexure B – prescribed assets;
   • Section 26(7) – contributions received later than three days after payment thereof became due in terms of the scheme’s rules;
   • Section 59 – payment of benefits within 30 days after the day on which the claim was received;
   • Regulation 29 read in conjunction with Regulation 30; and
   • Section 36(10) and 36(11) – Audit Committee composition.

7. Schemes are required to apply for exemption in terms of the Act if they do not comply with any provisions of the Act.

8. 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):
APPENDIX I – COMMON PROBLEM AREAS IDENTIFIED BY THE COUNCIL FOR MEDICAL SCHEMES

- Nature and impact;
- Causes of the failure; and
- Corrective course of action (including the timeframe, where applicable).

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

The examples and policies provided in this Guide are for guidance purposes only and all medical schemes should apply themselves and ensure their policies and disclosures reflect what is applicable to their scheme.
1. ILLUSTRATIVE STATEMENT OF FINANCIAL POSITION

<table>
<thead>
<tr>
<th>Name of Medical Scheme</th>
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<td>(Registration Number: 1234)</td>
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STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER 20XX

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>Notes</th>
<th>20XX (CY)</th>
<th>20YY (PY)</th>
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<tr>
<td>Non-current assets</td>
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<td>Property and equipment</td>
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<td>Investment property</td>
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<td>Available-for-sale investments / Financial assets at fair value through profit or loss:</td>
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<td>Scheme</td>
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<td>Trust</td>
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<tr>
<td>Loans and receivables</td>
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<tr>
<td>Current assets</td>
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<tr>
<td>Available-for-sale investments / Financial assets at fair value through profit or loss:</td>
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<tr>
<td>Loans and receivables</td>
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<tr>
<td>Cash and cash equivalents</td>
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<td>Note 2</td>
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<tr>
<td>Total Assets</td>
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<thead>
<tr>
<th>FUNDS AND LIABILITIES</th>
<th>Notes</th>
<th>20XX (CY)</th>
<th>20YY (PY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members' Funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated funds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluation reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale fair value reserve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement benefit obligations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance lease liability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Medical Savings Account liability</td>
<td></td>
<td></td>
<td>Note 3</td>
</tr>
<tr>
<td>Outstanding claims provision</td>
<td></td>
<td></td>
<td>Note 4</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td></td>
<td></td>
<td>Note 5</td>
</tr>
<tr>
<td>Total funds and liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. **ILLUSTRATIVE STATEMENT OF COMPREHENSIVE INCOME**

<table>
<thead>
<tr>
<th>Name of Medical Scheme</th>
<th>(Registration Number: 1234)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 20XX</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Notes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Risk contribution income</strong></td>
<td>Note 6</td>
</tr>
<tr>
<td><strong>Relevant healthcare expenditure</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Net claims incurred</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Risk claims incurred</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Third party claims recoveries</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Accredited managed healthcare services (no risk transfer)</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Net (expense)/income on risk transfer arrangement</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Risk transfer arrangement premiums paid</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recoveries from risk transfer arrangements</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Profit or loss share arising from risk transfer arrangements</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gross healthcare result</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Net income/(expenses) on commercial reinsurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reinsurance premiums paid</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recoveries from reinsurer</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Profit or loss share arising from reinsurance arrangements</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Broker service fees</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Administration fees and other operative expenses</strong></td>
<td>Note 7</td>
</tr>
<tr>
<td><strong>Net impairment losses on healthcare receivables</strong></td>
<td>Note 13.3.2</td>
</tr>
<tr>
<td><strong>Net healthcare result</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other income</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Investment income</strong></td>
<td>Note 8</td>
</tr>
<tr>
<td><strong>Income from use of own facilities by external parties</strong></td>
<td>Note 9</td>
</tr>
<tr>
<td><strong>Grants</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other operating income</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other expenditure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Interest paid</strong></td>
<td>Note 8</td>
</tr>
<tr>
<td><strong>Asset management fees</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sundry expenses</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cost incurred in provision of own facilities to external parties</strong></td>
<td>Note 9</td>
</tr>
<tr>
<td><strong>NET SURPLUS FOR THE YEAR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other comprehensive income</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Fair value adjustment on available-for-sale investments</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reclassification adjustment on realised gains</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Land and building revaluation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL COMPREHENSIVE INCOME FOR THE YEAR</strong></td>
<td></td>
</tr>
</tbody>
</table>
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 XXX

<table>
<thead>
<tr>
<th>Link to Notes</th>
<th>Accumulated funds</th>
<th>Available for –sale–investment reserve</th>
<th>Total members’ funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 1 January 20YY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net surplus for the year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realised gains on disposal of available – for-sale investments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealised gains on revaluation of available- for- sale investments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Comprehensive income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance as at 31 December 20YY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Balance as at 1 January 20XX |                  |                                       |                     |
| Net surplus for the year |                  |                                       |                     |
| Other comprehensive income |                  |                                       |                     |
| Realised gains on disposal of available– for-sale investments |                  |                                       |                     |
| Unrealised gains on disposal of available– for-sale investments |                  |                                       |                     |
| Total Comprehensive Income |                  |                                       |                     |
| Balance as at 31 December 20XX |                  |                                       |                     |
ILLUSTRATIVE STATEMENT OF CASH FLOWS

Name of Medical Scheme
(Registration Number: 1234)
STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 2017

<table>
<thead>
<tr>
<th></th>
<th>20XX R'000</th>
<th>20YY R'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash receipts from members and providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash receipts from members- contribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash receipts from members and provider- other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash paid to providers, employees and members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash paid to providers and employees- claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash paid to providers and employees- non healthcare expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash paid to members- savings plan refunds</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash generated from(used in) operations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Cash from (used In) operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of property, plant and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds on disposal of property, plant and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of investment property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds on disposal of investment property</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds on disposal of investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividend received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rentals received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from(Used in) investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Repayments)/Increase in borrowings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from(used in) financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash and cash equivalents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-as previously reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Prior year adjustment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash flows upon consolidation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer of cash and cash equivalents due to amalgamation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at the end of the year</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following IFRS and amendments to IFRS may affect financial statements for annual periods ending after 31 December 2016. The table was drawn up on 30 July 2015 and may not include all pronouncements subsequent to that date.

The following standards are expected to be applicable to medical schemes:

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Standard, Amendment or Interpretation</th>
<th>Summary of Requirements</th>
<th>Early Application Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual periods beginning on or after 1 January 2018</td>
<td>IFRS 9 Financial Instruments</td>
<td>On 24 July 2014 the IASB issued the final IFRS 9 Financial Instruments Standard, which replaces earlier versions of IFRS 9 and completes the IASB’s project to replace IAS 39 Financial Instruments: Recognition and Measurement. This standard will have an impact on the scheme, which will include changes in the measurement bases of the scheme’s financial assets to amortised cost, fair value through other comprehensive income or fair value through profit or loss. Even though these measurement categories are similar to IAS 39, the criteria for classification into these categories are significantly different. In addition, the IFRS 9 impairment model has been changed from an “incurred loss” model in IAS 39 to an “expected credit loss” model. The standard is effective for annual periods beginning on or after 1 January 2018 with retrospective application, early adoption is permitted [please update if the temporary exemption has been applied].</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual periods beginning on or after 1 January 2016</td>
<td>Amendment to IAS 16, 'Property, plant and equipment' and IAS 38, 'Intangible assets', on depreciation and amortisation.</td>
<td>In this amendment the IASB has clarified that the use of revenue based methods to calculate the depreciation of an asset is not appropriate because revenue generated by an activity that includes the use of an asset generally reflects factors other than the consumption of the economic benefits embodied in the asset. The IASB has also clarified that revenue is generally presumed to be an inappropriate basis for measuring the consumption of the economic benefits embodied in an intangible asset.</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual periods beginning on or after 1 January 2018</td>
<td>IFRS 15 – Revenue from contracts with customers</td>
<td>Establishes principles for accounting the nature, amount, timing and uncertainty of revenue arising from an entity’s contracts with customers.</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual periods beginning on or after 1 January 2021</td>
<td>IFRS 4 Insurance Contracts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. INVESTMENTS

ACCOUNTING POLICY

Financial assets

Classification

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.

(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. The scheme’s loans and receivables comprise ‘trade and other receivables’ and ‘cash and cash equivalents’ in the statement of financial position.

(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.
Recognition and measurement

Regular purchases and sales of financial assets are recognised on the trade-date – the date on which the scheme commits to purchase or sell the asset. Investments are initially recognised at fair value plus transaction costs for all financial assets not carried at fair value through profit or loss. Financial assets carried at fair value through profit or loss are initially recognised at fair value, and transaction costs are expensed in the statement of comprehensive income.

Financial assets are derecognised when the rights to receive cash flows from the investments have expired or have been transferred and the scheme has transferred substantially all risks and rewards of ownership. Available-for-sale financial assets and financial assets at fair value through profit or loss are subsequently carried at fair value. Loans and receivables are subsequently carried at amortised cost using the effective interest method.

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 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 Net investment income when the scheme’s right to receive payments is established. Changes in the fair value of monetary and non-monetary securities classified as available for sale are recognised in other comprehensive income. When securities classified as available for sale are sold or impaired, the accumulated fair value adjustments recognised in members’ funds are included in the statement of comprehensive income as part of ‘Net investment income.’

Interest on available-for-sale securities calculated using the effective interest method is recognised in the statement of comprehensive income as part of investment income. Dividends on available-for-sale equity instruments are recognised in the statement of comprehensive income as part of investment income when the scheme’s right to receive payments is established.

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.

Impairment of financial assets

(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.

Evidence of impairment may include indications that the debtors or a group of debtors is experiencing significant financial difficulty, default or delinquency in interest or principal payments, the probability that they will enter bankruptcy or other financial reorganisation, and where observable data indicate that there is
a measurable decrease in the estimated future cash flows, such as changes in arrears or economic conditions that correlate with defaults.

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 a loan or held-to-maturity investment has a variable interest rate, the discount rate for measuring any impairment loss is the current effective interest rate determined under the contract. As a practical expedient, the scheme may measure impairment on the basis of an instrument’s fair value using an observable market price.

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 members’ funds 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 the statement of comprehensive income. 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. Impairment losses recognised in the statement of comprehensive income on members’ funds instruments are not reversed through the statement of comprehensive income.
### NOTE DISCLOSURE

<table>
<thead>
<tr>
<th>Scheme</th>
<th>20xx R’000</th>
<th>20yy R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listed equity securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed deposits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money market</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The effective interest rate on the money market investments was x% (20yy:y%) and the investments have an average maturity of xxx days.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>20xx R’000</th>
<th>20yy R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recoveries from members and suppliers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total receivables arising from insurance contracts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sundry receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total arising from financial receivables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total trade and other receivables</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **CASH AND CASH EQUIVALENTS**

---

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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

<table>
<thead>
<tr>
<th></th>
<th>20xx</th>
<th>20yy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank accounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed deposits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total cash and cash equivalents</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 statement of comprehensive income.
3. PERSONAL MEDICAL SAVINGS ACCOUNT LIABILITY

ACCOUNTING POLICY

The personal medical savings account 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 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 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.

The personal medical savings accounts are invested 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

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

<table>
<thead>
<tr>
<th>20xx</th>
<th>20yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance of savings account balances at the beginning of the year [credit balances]</td>
<td>R’000</td>
</tr>
<tr>
<td>Add:</td>
<td></td>
</tr>
<tr>
<td>Savings account contribution received</td>
<td></td>
</tr>
<tr>
<td>Transfers from other schemes in terms of Regulation 10(4)</td>
<td></td>
</tr>
<tr>
<td>Interest and other income earned on monies invested in terms of the rules of the scheme</td>
<td></td>
</tr>
<tr>
<td>Less:</td>
<td></td>
</tr>
<tr>
<td>Claims Paid out of savings</td>
<td></td>
</tr>
<tr>
<td>Refunds on death or resignation in terms of regulation 10(5)</td>
<td></td>
</tr>
<tr>
<td>Transfers to other schemes in terms of Regulation 10(4)</td>
<td></td>
</tr>
<tr>
<td>Balances due to members on personal medical savings account balances held at the end of the year [Credit balances only]</td>
<td></td>
</tr>
</tbody>
</table>

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 enrol 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 judgement 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 judgement 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;\(^2\)
- Interest is allocated to members with positive PMSA balances in accordance with the rules of the scheme.

4. TRADE AND OTHER PAYABLES

**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

\(^2\) 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, these assets do not need to be separately disclosed.
recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

### NOTE DISCLOSURE

<table>
<thead>
<tr>
<th></th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Risk contributions receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reported claims(Contributions Outstanding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member + Service provider claims receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total liabilities arising from insurance contracts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sundry account Receivable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current portion of non-current borrowings</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total arising from any financial trade receivables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total trade and other payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported claims not yet paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at beginning of year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements of year [specify]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at end of year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>Covered by risk transfer arrangements</th>
<th>Not covered by risk transfer arrangements</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 20XX                                 |                                          |       |
|--------------------------------------|                                          |       |
| Provision for outstanding risk claims – incurred but not yet reported | | |
| Provision arising from liability adequacy test | | |

#### Analysis of movements in outstanding risk claims

<table>
<thead>
<tr>
<th>Balance at the beginning of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments in respect of prior year</td>
</tr>
<tr>
<td>Over/under provision in prior year</td>
</tr>
<tr>
<td>Adjustment of current year</td>
</tr>
</tbody>
</table>

**Balance at end of year**

#### Analysis of movements in provision arising from liability adequacy test

<table>
<thead>
<tr>
<th>Balance at the beginning of year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments in respect of prior year</td>
</tr>
<tr>
<td>Over/under provision in prior year</td>
</tr>
<tr>
<td>Adjustment for current year</td>
</tr>
<tr>
<td><strong>Balance at year end</strong></td>
</tr>
</tbody>
</table>
Outstanding Risk Claims Provision Continued

<table>
<thead>
<tr>
<th>Covered by risk transfer arrangements</th>
<th>Not covered by risk transfer arrangements</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 deterministic 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.

Impact on surplus reported caused by reasonable possible changes in key variables

<table>
<thead>
<tr>
<th>Change in variable</th>
<th>Change in liability 20xx R’000</th>
<th>Change in liability 20yy R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic claims ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Above-threshold benefit claims ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual claims as percentage of total claims</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

*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*
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 surplus/ (deficit) for the period. It should be noted that increases in liabilities will result in decreases in surplus 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**

<table>
<thead>
<tr>
<th></th>
<th>20xx</th>
<th>20yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross contributions per registered rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal medical savings account contributions received*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk contribution income per statement of comprehensive income</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Savings contributions are received by the scheme in terms of Regulation 10(1) and the scheme’s registered rules. 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.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>20XX</th>
<th>20YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums/fees paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims incurred in respect of related risk transfer arrangements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recoveries received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profit/(loss) share on risk transfer arrangement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net income/(expense)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[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.]

### 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**

<table>
<thead>
<tr>
<th>Broker service fee</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brokers’ fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other distribution costs paid to brokers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

TRUSTEES’ REMUNERATION AND CONSIDERATIONS #

<table>
<thead>
<tr>
<th>Fees for meeting attendance</th>
<th>Fees for holding of office</th>
<th>Fees for consultancy services</th>
<th>Other Remuneration</th>
<th>Total Remuneration</th>
<th>Training</th>
<th>Total Remuneration</th>
<th>Total Remuneration</th>
<th>Total Remuneration</th>
<th>Total Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Travelling and other expenses for meetings and conferences</th>
<th>Telephone expenses</th>
<th>Accommodation and meals</th>
<th>Other disbursements and reimbursements</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
<td>R’000</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Scheme</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial assets at fair value through profit or loss:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dividend income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interest income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available – for-sale financial assets dividend income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans and receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents interest income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net realised gains on available – for-sale financial assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net gains or losses on financial assets at fair value through profit or loss</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.1 Net realised gains or losses available – for-sale financial assets</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Realised gains on financial assets available-for-sale:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Equity securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Money market</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Realised losses on financial assets available-for-sale:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Equity securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Money market</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8.2 Net gains or losses on financial assets at fair value through profit or loss</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net fair value gains on financial assets at fair value through profit or loss, including derivatives:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Equity Securities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Money Market</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net fair value losses on financial assets at fair value through profit and loss, including derivatives:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Equity securities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Net fair value gains on non-derivative financial assets at fair value through profit or loss relate entirely to assets designated to be in this category upon initial recognition. Fair value gains on money market instruments exclude interest\(^4\).

<table>
<thead>
<tr>
<th>Other Income</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on balances due by administrator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unallocated amounts written back as prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outdated cheques written back</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Interest Paid                                         |             |            |
| Financial liabilities not at fair value through profit or loss: |             |            |
| Interest on personal medical savings accounts monies   |             |            |

9. **SURPLUS/(DEFICIT) 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 surplus or deficit 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.

**NOTE DISCLOSURE**

<table>
<thead>
<tr>
<th>Surplus/(deficit) from operations per benefit option</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from services rendered to third parties</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Less:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total costs incurred in operating own facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total healthcare provider costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in inventories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration expenses (including salaries)</td>
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<td></td>
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<tr>
<td>Other costs incurred in operating own facility</td>
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<td><strong>Add:</strong></td>
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</tbody>
</table>

\(^4\) Depending on the investment, money market instruments could be classified as loans and receivables.
The scheme provides healthcare services to third parties in its own facilities, which generates its own revenue for the services rendered.

10. **SURPLUS/ (DEFICIT) 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

SURPLUS/(DEFICIT) 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]

<table>
<thead>
<tr>
<th></th>
<th>ACB Comprehensive Option R’000</th>
<th>ACB 70/100 Option R’000</th>
<th>ACB Major Events Option R’000</th>
<th>Total Scheme R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>20XX</strong></td>
<td>[insert line per statement of comprehensive income]</td>
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<tr>
<td>Surplus/(deficit) for the year</td>
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<tr>
<td>Number of members</td>
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<tr>
<td>Number of beneficiaries</td>
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<tr>
<td>Average age</td>
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<tr>
<td>Pensioner ratio</td>
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<tr>
<td><strong>20YY</strong></td>
<td>[Insert line per statement of comprehensive income]</td>
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<tr>
<td>Surplus/(deficit)for the year</td>
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<tr>
<td>Number of members</td>
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<td>Number of beneficiaries</td>
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<tr>
<td>Average age</td>
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</tr>
<tr>
<td>Pensioner Ratio</td>
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<td></td>
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</tbody>
</table>
11. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

ACCOUNTING POLICY

This illustrative note only addresses areas of critical accounting judgement 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 judgements that have the most significant effect on the amounts recognised in the financial statements.

Certain critical accounting judgements 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

<table>
<thead>
<tr>
<th>Age grouping (in years)</th>
<th>General Practitioners R’000</th>
<th>Specialists R’000</th>
<th>Dentistry R’000</th>
<th>Optometry R’000</th>
<th>Medicines R’000</th>
<th>Hospital R’000</th>
<th>Total R’000</th>
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<tbody>
<tr>
<td>&lt; 26 Gross</td>
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### 20YY

<table>
<thead>
<tr>
<th>Age grouping (in years)</th>
<th>General Practitioners R’000</th>
<th>Specialists R’000</th>
<th>Dentistry R’000</th>
<th>Optometry R’000</th>
<th>Medicines R’000</th>
<th>Hospital R’000</th>
<th>Total R’000</th>
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<tr>
<td>&lt; 26</td>
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</tbody>
</table>

[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**

<table>
<thead>
<tr>
<th>Age Grouping in years</th>
<th>In-Hospital</th>
<th>Chronic</th>
<th>Day-to-day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PMB R’000</td>
<td>Non-PMB R’000</td>
<td>PMB R’000</td>
<td>Non-PMB R’000</td>
</tr>
<tr>
<td>&lt; 26</td>
<td>Gross</td>
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<td>Net</td>
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<td>26-35</td>
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<td><strong>Total</strong></td>
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</table>
20YY

<table>
<thead>
<tr>
<th>Age Grouping in years</th>
<th>In-Hospital</th>
<th>Chronic</th>
<th>Day-to-day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PMB</td>
<td>Non-PMB</td>
<td>PMB</td>
<td>Non-PMB</td>
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<tr>
<td>&lt; 26</td>
<td>Gross</td>
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<td>Net</td>
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<td>26-35</td>
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</tbody>
</table>

[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 capititation 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:

<table>
<thead>
<tr>
<th></th>
<th>General practitioners</th>
<th>Specialists</th>
<th>Dentistry</th>
<th>Optometry</th>
<th>Medicines</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>20%</td>
<td>2%</td>
<td>1%</td>
<td>20%</td>
<td>-</td>
<td>15%</td>
</tr>
<tr>
<td>Option 2</td>
<td>5%</td>
<td>20%</td>
<td>2%</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
</table>

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 DISCLOSURES TO THE FINANCIAL STATEMENTS

#### 13. FAIR VALUES AND FINANCIAL RISK MANAGEMENT

<table>
<thead>
<tr>
<th>Financial assets at fair value through profit or loss</th>
<th>Financial liabilities at fair value through profit or loss</th>
<th>Fair value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Designated upon initial recognition</td>
<td>Classified as held for trading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loans and receivables</td>
<td>Available-for-sale financial assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated upon initial recognition</td>
<td>Classified as held for trading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial liabilities measured at amortised cost</td>
<td>Insurance receivables and payables **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total carrying amount</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>20xx</th>
<th>R'000</th>
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<tr>
<td>Bonds and debentures</td>
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<tr>
<td>Equity investments</td>
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</tr>
<tr>
<td>Unlisted investments</td>
<td></td>
<td></td>
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<tr>
<td>Cash and cash equivalents</td>
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<td></td>
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<tr>
<td>Trade and other receivables*</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Personal medical savings account liability*</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Trade and other payables*</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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.]

13.2. Measurement of fair values

13.2.1. 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

<table>
<thead>
<tr>
<th>Type</th>
<th>Valuation technique</th>
<th>Significant unobservable inputs</th>
<th>Inter-relationship between significant unobservable inputs and fair value measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bonds and Debentures</td>
<td>Describe the valuation technique used by the scheme to determine the fair value(e.g. discounted cash flows, market comparison etc.)</td>
<td>Disclose the significant unobservable inputs used in determining the fair value(Level 3 only)</td>
<td>Disclose how the fair value would change(e.g. increase or decrease) if one or more of the significant unobservable Inputs used changes.</td>
</tr>
<tr>
<td>- Equity investments</td>
<td>The fair value(e.g. discounted cash flows, market comparison etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlisted Investments</td>
<td>Market comparison, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Financial instruments not measured at fair value

<table>
<thead>
<tr>
<th>Type</th>
<th>Valuation technique</th>
<th>Significant unobservable inputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borrowings:</td>
<td>Describe the valuation technique used by the scheme to determine the fair value(e.g. discounted cash flows, market comparison etc.)</td>
<td>Disclose the significant unobservable inputs used in determining the fair value(Level 3 only)</td>
</tr>
</tbody>
</table>

13.2.2. 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]
13.2.3. Level 3 fair values

Disclosure example of reconciliation of Level 3 fair values

<table>
<thead>
<tr>
<th>Financial assets at fair value through profit and loss</th>
<th>Available – for-sale financial assets</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonds R’000</td>
<td>Equity investments R’000</td>
<td></td>
</tr>
<tr>
<td>Equity Investments R’000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 surplus/(deficit) for assets held 31 December 20XX**

Note: comparative information also has to be presented and a similar table might be presented for financial liabilities
APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

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], reasonably possible changes at the reporting date to one of the significant unobservable inputs, holding other inputs constant, would have the following effects:

<table>
<thead>
<tr>
<th>Equity securities – Available-for-sale</th>
<th>OCI, net of tax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase</td>
</tr>
<tr>
<td>20xx</td>
<td>R’000</td>
</tr>
</tbody>
</table>

[insert significant observable input here] (xx% movement)
[insert significant observable input here] (xx% movement)

<table>
<thead>
<tr>
<th>Equity securities – Designated as at fair value through profit or loss</th>
<th>Profit or loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>20xx</td>
<td></td>
</tr>
</tbody>
</table>

[insert significant observable input here] (xx% movement)
[insert significant observable input here] (xx% movement)

13.3. Financial risk management

The Scheme has exposure to the following risks from financial instruments:

- Credit risk;
- Liquidity risk; and
- Market risk.

<table>
<thead>
<tr>
<th>20xx</th>
<th>Credit Risk</th>
<th>Liquidity Risk</th>
<th>Equity Price</th>
<th>Market risk Interest rate</th>
<th>Currency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bonds and debentures (listed)</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Equity investments</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Unlisted investments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>x</td>
<td></td>
<td>x*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables*</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal medical savings account liability</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables*</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBNR</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.]

13.3.1. 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.]

13.3.2. 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 disclosed by class, including the quantitative analysis and maximum credit exposure at the end of year.

<table>
<thead>
<tr>
<th>Class A</th>
<th>Class B</th>
<th>Class C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subclass R’000</td>
<td>Subclass R’000</td>
<td>Subclass R’000</td>
<td>Subclass R’000</td>
</tr>
</tbody>
</table>

**Financial assets that are neither past due nor impaired**

**Age Analysis**

- > 0 - 30 days
- > 31 – 60 days
- > 61 – 90 days
- > 90 days

**Financial assets that are impaired**

**Carrying amount impairment**

**Total Credit exposure**

**Collateral held:**

*(Provide details)*

**Impairment losses**
Paragraph 16 requires reconciliation between the opening and closing balance of the allowance account for impairment losses. This reconciliation needs to be conducted per class of financial asset. In addition to these requirements, paragraph 20(e) also requires disclosure of the impairment loss recognised in the profit or loss per class of financial asset.

**Example 1: The scheme makes use of an allowance account for impairment losses**

The following note is an example of the disclosure requirements in terms of IFRS 7 paragraph 16 and paragraph 20(e):

The movement in the allowance for impairment, for each class of financial asset, during the year was as follows:

<table>
<thead>
<tr>
<th>Trade and other Receivables</th>
<th>Contributions receivable</th>
<th>Broker fee receivable</th>
<th>Risk transfer arrangement receivable</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance as at 1 January 20XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts recognised in the statement of comprehensive income for the period (refer to note XX)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional impairments in the period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unused amounts reserved during the period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts utilised during the period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance as at 31 December 20XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example 2: The scheme makes use of an allowance account for impairment losses, and recognises some impairment losses directly in profit or loss**

The following disclosure is additional to the disclosure shown in Example 1 (in terms of the requirement of paragraph 20(e)):

The impairment loss per class of financial asset recognised in the statement of comprehensive income is as follows:

<table>
<thead>
<tr>
<th>Trade and other Receivables</th>
<th>Insurance receivables</th>
<th>Other</th>
<th>Unlisted Investments</th>
<th>Bonds and debentures</th>
<th>Total</th>
</tr>
</thead>
</table>
APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

<table>
<thead>
<tr>
<th>Movement in the allowance account for impairment losses</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment losses recognised directly in the statement of comprehensive income (refer to note xx)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The movement in the allowance account for impairment losses should agree to the “Amount recognised in the statement of comprehensive income for the period” in reconciliation of the movement in the allowance account for impairment losses in example 1.

**Example 3: Impairment losses are recognised directly in the statement of comprehensive income, and the scheme does not make use of an allowance account**

When impairment losses are recognised directly in the statement of comprehensive income (and the scheme does not make use of an allowance account), IFRS 7 paragraph 20(e) requires that the amount of any impairment loss should be disclosed for each class of financial asset. The following note is an example of the disclosure requirements:

<table>
<thead>
<tr>
<th>The impairment loss per class of financial asset recognised directly in the statement of comprehensive income is as follows:</th>
<th>20XX</th>
<th>20YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>R’000</td>
<td>R’000</td>
<td></td>
</tr>
<tr>
<td>Insurance receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bonds and Debentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlisted Investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Insurance receivables included amounts due from:
- Contribution debtors
- Brokers
- Reinsurance
- MVA/Fraud/COID recoveries
- Provider balances
- Member balances excluding balances from personal medical savings accounts

**13.3.3. 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 maturities\(^5\) of financial liabilities at reporting date. The amounts are gross and undiscounted, and include estimated interest payments and exclude the impact of netting agreements:

<table>
<thead>
<tr>
<th>Financial Liabilities</th>
<th>Months R’000</th>
<th>Months R’000</th>
<th>Months R’000</th>
<th>Years R’000</th>
<th>Years R’000</th>
<th>Years R’000</th>
<th>Total R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Personal Medical savings accounts liability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Trade and other payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outstanding risk claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

13.3.4. 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

\(^5\) IFRS 7 does not mandate the number of time bands to be used in the contractual maturity analysis. The Scheme should apply judgement to determine the appropriate number of time bands.
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 Surplus for the year ended 31 December 20xx would decrease/increase by RXXX (20yy: decrease/increase by RXXX). This is mainly attributable to the Scheme’s exposure to interest rates on its variable rate borrowings and investments.

Fixed-rate instruments

The Scheme does not account for any fixed-rate financial assets or financial liabilities as at fair value through profit or loss. Therefore, a change in interest rates at the reporting date would not affect profit or loss.

A change of xx basis points in interest rates would have increased or decreased equity by Rxxx after tax (20yy:Rxx).

Equity price sensitivity analysis

[explain how the Scheme manages its risk]

Sensitivity analyses

The sensitivity analyses below have been determined based on the exposure to equity price risks at the reporting date.

If equity prices had been x% higher/lower:

- Net surplus 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]

---

6This would be relevant only if debt instruments have been classified as available for sale.
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.

The accumulated funds ratio is calculated as follows:

<table>
<thead>
<tr>
<th></th>
<th>20XX</th>
<th>20YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total members’ funds per SFP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Unrealised investment gains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated funds per Regulation 29 of the Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross annual contribution income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100</td>
<td>XX%</td>
<td>YY%</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Number of investee funds</th>
<th>Net asset value of investee fund (range and weighted average)</th>
<th>Fair value of fund’s assets of investment Rxxx*</th>
<th>% of net assets attributable to scheme**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund of Funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 2017, total net losses incurred on investments in the funds were Rxxxx.

**Disclosure for subsidiaries**

*Accounting policy note reflecting the new 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

<table>
<thead>
<tr>
<th>Name of entity</th>
<th>Place of business/Country of incorporation</th>
<th>% of ownership interest held by the scheme</th>
<th>% of ownership interest held by the non-controlling interests (NCI)</th>
<th>Principal activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>South Africa</td>
<td>100</td>
<td>0</td>
<td>Investments of funds for returns and capital growth</td>
</tr>
<tr>
<td>Accredited Managed Healthcare Organisations</td>
<td>South Africa</td>
<td>85</td>
<td>15</td>
<td>Accredited managed healthcare service provider</td>
</tr>
</tbody>
</table>

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 (2013 – Rxxxx).

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.

<table>
<thead>
<tr>
<th>Summarised statement of financial position</th>
<th>Hospital</th>
<th>Accredited Managed Healthcare Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 December 20XX</td>
<td>31 December 20YY</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated NCI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX II – ILLUSTRATIVE DISCLOSURES TO THE FINANCIAL STATEMENTS

<table>
<thead>
<tr>
<th>Summarised statement of comprehensive income</th>
<th>Hospital</th>
<th>Accredited Managed Healthcare Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 December 20xx R’000</td>
<td>31 December 20yy R’000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) for the period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) allocated to NCI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends paid to NCI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summarised cash flows*</th>
<th>Hospital</th>
<th>Accredited Managed Healthcare Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 December 20xx R’000</td>
<td>31 December 20yy R’000</td>
</tr>
<tr>
<td>Cash flows from operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash flows from investing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash flows from financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash and cash equivalents</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 judgements 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 scheme 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 judgements 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.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Number of investee funds</th>
<th>Net asset value of investee fund (range and weighted average)</th>
<th>Fair value of fund’s assets of investment Rxxx*</th>
<th>% of net assets attributable to scheme**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund of Funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 2017, total net losses incurred on investments in the funds were Rxxxx.
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>% equity interest</th>
<th>20xx</th>
<th>20yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC (Pty) Ltd</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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 includes 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

<table>
<thead>
<tr>
<th></th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compensation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short term employee benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-employment pension and medical benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other long term benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total compensation paid to key management personnel</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Nature of transactions and terms and conditions thereof</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution received</td>
<td>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.</td>
</tr>
<tr>
<td>Claims incurred</td>
<td>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.</td>
</tr>
<tr>
<td>Contribution debtor</td>
<td>This constitutes outstanding contributions payable. The amounts are due immediately. No provisions for doubtful debts have been raised on these amounts.</td>
</tr>
<tr>
<td>Claims reported not yet paid</td>
<td>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.</td>
</tr>
<tr>
<td>Personal medical savings accounts</td>
<td>The amounts owing to the related parties relate to medical aid savings balances. 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.</td>
</tr>
<tr>
<td>Healthcare provider fees paid/payable</td>
<td>Fees paid to a healthcare provider (medical practitioner). Fees are paid on the same basis as applicable to third parties.</td>
</tr>
</tbody>
</table>

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.
## APPENDIX II – ILLUSTRATIVE DISCLOSURES TO THE FINANCIAL STATEMENTS

<table>
<thead>
<tr>
<th>Party</th>
<th>20XX R’000</th>
<th>20YY R’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sponsoring Employee</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EFG – Employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant Received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent Paid</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of financial Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent Due</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parties that provide key management personnel services to the scheme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIJ-Administrator*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration fees recovered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site office costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent received</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of financial Position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration fees due</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOP-Accredited managed care organisation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accredited managed healthcare service fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of financial position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accredited managed healthcare service fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>QRS- Investment manager</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of financial position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment fees due</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TUV – Broker</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of Comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broker Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Statement of Financial position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broker fees due</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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):

<table>
<thead>
<tr>
<th>Benefit option</th>
<th>Nr of members</th>
<th>Net healthcare deficit</th>
<th>Net result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option XX</td>
<td>70</td>
<td>(8 267)</td>
<td>2 100</td>
</tr>
<tr>
<td>Option XY</td>
<td>100 000</td>
<td>(456 789)</td>
<td>(210 711)</td>
</tr>
</tbody>
</table>

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.