



The South African Institute of Chartered Accountants

# **MEDICAL SCHEMES ACCOUNTING AND AUDITING GUIDE**

## **FOR THE YEAR END 31 DECEMBER 2006**

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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 (the Council), 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, for auditors of medical schemes, International Standards on Auditing (ISAs), 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, IFRS and ISAs, 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 the advice given in this guide is correct. Nevertheless that 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 relate to the contents of this guide.*

# INTRODUCTION

- .01 Throughout this guide the term “medical scheme” refers to a scheme that carries on the business of a medical scheme registered under the Medical Schemes Act, 1998, as amended (the Act) and the regulations thereto (the regulations). This will exclude healthcare insurance products provided by a long-term or short-term insurer registered in terms of the Long-term Insurance Act, 1998 or the Short-term Insurance Act, 1998.
- .02 The organisations providing healthcare funding in the Republic of South Africa are classified as not for profit medical schemes registered under the Act.
- .03 The basic source of business is from employers that wish to arrange healthcare benefits for their employees and their employees’ dependants and from individuals that wish to cover themselves and/or their dependants. Some medical schemes are formed with the primary purpose of supporting employees of particular organisations, or 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, and these are called open medical schemes.
- .04 Business is introduced to medical schemes by direct selling 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 contract is renewable annually and the period 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, including the following:
  - Death of member.
  - Prior termination of the contract, in terms of the rules, by either party.
  - Liquidation of the medical scheme.
- .05 In practice, an employer may negotiate contracts for membership of a medical scheme on behalf of its employees. Individuals may join any open medical scheme in their personal capacity or a restricted medical scheme should they qualify for membership.
- .06 Contributions are paid as determined by the rules of the medical scheme in compliance with section 26(6) and 26(7) of the Act, and the medical scheme undertakes to accept, either wholly or in part, the risks arising from providing healthcare services to the member and the member’s dependants, in terms of healthcare benefits defined in the rules of the medical scheme.
- .07 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. Healthcare benefit limits 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 for a medical scheme registered in terms of the Act. Unexpended benefits may not be accumulated by a beneficiary from one year to the next other than provided for in the personal medical savings accounts.

- .08 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. 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. 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. Premiums/fees and recoveries for claims relating to risk transfer arrangements are shown separately in respect of each risk transfer arrangement in order that the financial extent of such arrangements may be clearly demonstrated.
- .09 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, 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.
- .10 Some medical schemes provide for member savings plan 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 savings plan account. While these savings belong to the member, they may only be used for healthcare services and are only refundable as provided for in Regulation 10.
- .11 Inherent in medical scheme operations is the fact that income, in the form of contributions, 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 Annexure B of the regulations.
- .12 A medical scheme needs to maintain minimum accumulated funds expressed as a percentage of gross annual contributions, which may not be less than 25%. 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.

# LEGISLATION

## **Medical Schemes Act 131, 1998, as amended (the Act)**

.01 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.”*

.02 Section 20 of the Act requires that every medical scheme 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.

.03 Sections 20(3) to 20(7) of the Act require certain conditions to be adhered to in respect of commercial reinsurance contracts entered into by a medical scheme.

.04 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.

- .05 Section 26(4) of the Act sets out the items that may be debited to a scheme's bank account.
- .06 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.
- .07 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.
- .08 Section 29A of the Act stipulates the conditions under which a medical scheme may apply general and specific waiting periods.
- .09 Section 33(2) of the Act contains provisions relating to the approval of new benefit option conditions that must be addressed to the satisfaction of the Registrar before approval of such benefit options can occur.
- .10 Section 35(6) of the Act states that a medical scheme shall not encumber its assets or directly/indirectly borrow money without the prior approval of, or subject to directives issued by, the Council.
- .11 Section 35(8) of the Act states that 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.
- .12 Section 37 of the Act sets out the documentation and information to be submitted to the office of the Registrar within the prescribed deadlines.
- .13 Section 57 of the Act sets out the duties of the Board of Trustees, which are significant to ensure good governance.
- .14 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.
- .15 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.
- .16 Managed care agreements are regulated in terms of Chapter 5 of the regulations. As defined in Regulation 15: "*Managed health care 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.*"
- .17 Administration of a medical scheme by a third party should comply with Chapter 6 of the regulations.
- .18 Conditions to be complied with by brokers are regulated by Chapter 7 of the regulations.
- .19 Chapter 7 of the Act contains provisions relating to the financial matters of a medical scheme, covering the following:
  - Financial arrangements (section 35);
  - The appointment of the auditor and the audit committee (section 36); and

- The annual financial statements (section 37).
- .20 The Registrar has the power to cancel or suspend the registration of a medical scheme if, after investigation, the Council is of the opinion that registration should be so cancelled or suspended.
  - .21 The Registrar may, with the consent of the Council, apply to the court for an order for judicial management, curatorship or winding up, in terms of the conditions laid down in the Act.
  - .22 Regulation 6A sets out the disclosure of trustees' remuneration.
  - .23 The minimum accumulated funds to be maintained by a medical scheme is regulated by Chapter 8 of the regulations.
  - .24 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 personal medical savings accounts.
  - .25 Regulation 10 stipulates the requirements in respect of savings accounts.
  - .26 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 member changes medical schemes or benefit options.
  - .27 Regulation 10(5) requires that credit balances in a member's personal medical savings account must be taken as a cash benefit, subject to applicable laws, when the member terminates his or her membership of a medical scheme or benefit option without enrolling in another medical scheme or enrolls in another medical scheme without a personal medical savings account provision or selects a benefit option without a savings plan.
  - .28 Regulation 23 states that an administrator must deposit any medical scheme moneys under administration, not later than the business day following the date of receipt of these moneys, into a bank account opened in the name of the medical scheme. When medical scheme moneys, including contributions, are paid by means of electronic funds transfer, such moneys shall be deposited directly into a bank account opened in the name of the medical scheme. Moneys received shall at no time be deposited in any bank account other than that of the medical scheme.
  - .29 Regulation 29 sets out the accumulated funds to be maintained by a medical scheme – the amount being 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.
  - .30 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.

- .31 The Minister of Health publishes regulations and the Registrar, from time to time, publishes directives that govern the operation of medical schemes.
- .32 This section of the guide provides a selection of important sections contained in the Act, and does not constitute a complete or comprehensive list. The relevant legislation and regulations can be accessed from the Council website. Any other relevant legislation should be considered by an auditor, including the following:
- Financial Advisory and Intermediary Services Act, 2002, as amended.
  - Financial Intelligence Centre Act, 2001, as amended.
  - Trust Property Control Act, 1988, as amended.
  - Companies Act, 1973, as amended.
  - Auditing Profession Act, 2005.
  - Prescription Act, 1969, as amended.

## DEFINITIONS USED IN THE GUIDE

*Accounting period* – in the case of annual financial statements is the financial year of the scheme.

*Administration expenses* – are costs incurred to administer the medical scheme.

*Auditor* – is a registered auditor as defined in the Auditing Profession Act, 2005, approved by the Council to act as auditor for a medical scheme.

*Beneficiary* – is a member or a person admitted as a dependant of a member.

*Benefit option* – is a defined set of healthcare benefits applicable to a specific group of members and/or employers that have selected such benefits in terms of the rules of the medical scheme.

*Claim* – is an amount, net of discount, payable to the provider or the member for healthcare benefits supplied to the member, in terms of the rules of the medical scheme.

*Commencement of cover* – is the date on which the risk commences, in terms of the rules of the medical scheme, in respect of a beneficiary's health cover.

*Co-payments* – see member's portion.

*Dependant* – is the spouse or partner, dependant 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.

*Employer* – is any employer group or sponsor that contracts with a medical scheme for and on behalf of its employees.

*Gross claims paid and reported* – are the total costs of settling all claims (before deducting claims paid from savings accounts) arising from healthcare events that have occurred in the period and those that have occurred previously, and for which no provision was made, including costs for managed care: healthcare services. Gross claims also include own facility cost for services rendered to members.

*Gross contribution income* – are amounts (premiums) payable by members and/or employers, in terms of the rules of the medical scheme, for the purchase of healthcare benefits. Gross contributions include savings plan contributions.

*Healthcare benefits* – are the members' entitlement to healthcare services, in terms of the rules of the medical scheme.

*Incurred but not reported reserve (IBNR)* – refer to definition of outstanding claims provision.

*Investment income* – includes interest, dividends, rental and policy income.

*Managed care* – means the management of member healthcare benefit entitlements by providing, and/or assessing, and/or facilitating the appropriateness and cost effectiveness of relevant healthcare services to members and their dependants including accepted clinical practices and treatment protocols. This process can be categorised into the following expenditure classifications:

- *Managed care: management services* – is the cost of managing healthcare expenditure, such as bill review, specialist and hospital referrals, case management, disease management (where healthcare benefits are not included in the contract), peer review, claims audits and statistical analysis, but does not include the cost of any relevant healthcare services; and
- *Managed care: healthcare services* – is the cost of healthcare services under payment systems, such as capitation fees (healthcare services purchased) and disease management (where healthcare service benefits are included in the contract).

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

*Member* – is a natural person, admitted to membership of a medical scheme, who is entitled to healthcare benefits, in terms of the rules of the medical scheme, in exchange for a contribution.

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

*Net claims incurred* – net claims paid and reported adjusted by the outstanding claims provision at the beginning and end of the accounting period.

*Net claims paid and reported* – 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 claims provision, net of recoveries from members for co-payments and savings plan accounts and discounts received.

*Net contribution income* – represents contributions for which the medical scheme is at risk, and is calculated as gross contributions less savings contributions, during the accounting period.

*Outstanding claims provision* – is a provision made for the estimated cost of healthcare benefits that have occurred before the end of the accounting period but 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 for savings plan accounts. This provision is also known as provision for unexpired claims incurred but not reported (IBNR).

*Own facility costs* – represent costs incurred by the medical scheme in operating its own medical equipment, hospital, clinic, pathology laboratory and radiology facility or any other related services.

*Registrar* – Registrar of/for Medical Schemes.

*Report of the Board of Trustees* – is the report by those persons with a fiduciary responsibility towards the 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 transfer arrangement* – is a contractual arrangement in terms of which a third party undertakes to indemnify a medical scheme against all or 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* – are those rules, constitutions and/or agreements, in terms of which the member receives healthcare benefits, and in terms of which the medical scheme is administered.

*Savings plan* – are saving plan contributions held on behalf of members to be used for payment of healthcare benefits that are for the account of the member, in terms of the rules of the medical scheme. A savings plan fund is shown as a liability of the medical scheme and is not included in the calculation of the minimum accumulated funds to be maintained by the medical scheme in terms of the regulations made under the Act. A credit balance of a member's savings plan account is only refundable as provided for in Regulation 10 of the Act.

*Solvency ratio* – is the accumulated funds, as defined by the Act, expressed as a percentage of annualised gross contributions for the accounting period under review. (The solvency ratio is sometimes referred to as the "accumulated funds ratio".)

# ACCOUNTING GUIDE

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## Objectives

- .01 The financial statements of a medical scheme are prepared in accordance with 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.
- .02 The overall objective of financial reporting is to achieve fair presentation. Refer to paragraphs 13 to 22 of 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 disclosure requirements regarding the various components of financial statements, including the significant accounting policies and other explanatory notes.
- .03 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.

## The impact of IFRS 4 – *Insurance Contracts*

- .04 IFRS 4 is the result of the first phase of the International Accounting Standards Board's (IASB's) 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. It is expected that the second phase of the IASB's project will address the recognition and measurement of insurance contracts more clearly. (For further information on IFRS 4, refer to Appendix IV in addition to what is set out below.)

## The definition of an insurance contract

- .05 IFRS 4 is applicable to all issuers of insurance contracts.
- .06 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 the legal form thereof. For this reason, a contract that is not an insurance contract from a legal perspective could be an insurance contract from an accounting perspective.
- .07 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.
- .08 A medical scheme should apply IFRS 4 to all medical benefit plans or contracts that are insurance contracts, as defined by IFRS 4. The medical scheme will be viewed as the insurer in applying IFRS 4.

- .09 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.

**Deposit components**

- .10 IFRS 4 requires, permits or prohibits 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.
- .11 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 savings plan, the risk portion may 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. (Refer to paragraph 48 for further information.)

**Liability adequacy test**

- .12 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 are 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 income statement.
- .13 At year end the medical schemes should:
- determine the carrying amount of all the relevant insurance liabilities (this would include, but would not be limited to, the outstanding claims provision, claims reported but not yet paid and contributions received in advance). It should be noted that related 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 income statement as part of the movement in the outstanding claims provision.
- .14 Contracts that are subject to broadly similar risks that are managed together as a single portfolio may be aggregated in applying the LAT.
- .15 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.
- .16 Medical schemes should, amongst other insurance-related liabilities, consider whether their IBNR calculation meets the requirements of the LAT.

### **Risk transfer arrangements**

- .17 A reinsurance contract is defined by IFRS 4 as an insurance contract issued by one insurer (the reinsurer) to compensate another insurer (the cedant) for losses on one or more contracts issued by the cedant. In this guide, contracts which meet the definition of reinsurance contracts in IFRS 4 are referred to as risk transfer arrangements. Income and expenses relating to risk transfer arrangements are disclosed separately in the income statement.
- .18 IFRS 4 requires the scheme to assess each contract separately for determining whether there is a transfer of insurance risk.
- .19 Medical benefit plans or contracts issued by the medical scheme to members expose 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, 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.
- .20 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.
- .21 A medical scheme should consider its assets under risk transfer arrangements (mainly comprising recoveries under risk transfer arrangements) 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.

### **Contribution income**

- .22 Contributions are recognised in the accounting period to which the related risks refer and should be in line with the rules of the 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.
- .23 In order for the overall size of a medical scheme's operations to be appreciated, the gross amount of contributions, which includes the savings plan contributions, is disclosed. Savings plan contributions are disclosed separately as a deduction from gross contributions. Net contributions disclosed are in respect of contributions directly relating to the risks carried by the medical scheme.
- .24 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.

## **Claims incurred**

- .25 When accounting for claims, a medical scheme recognises the total estimated cost, net of recoveries from members for co-payments and savings plan accounts, of settling all claims arising from healthcare costs that have been incurred in the period, whether or not reported by the end of the period. Provisions are made at the reporting date for the estimated cost, net of estimated recoveries from members for co-payments and savings plan accounts, of all claims not settled at that date, whether arising from events occurring during that period or earlier periods, and whether or not notified before the close of the accounting period.
- .26 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 schemes should amalgamate the results as at the date of amalgamations. Claims relating to the run-off period would form part of the claims reported.
- .27 With reference to paragraphs .24 and .25 above, claims incurred include the following items:
- Claims submitted and accrued for services rendered during the accounting period, net of recoveries from members for co-payments and savings plan accounts.
  - Movement in the provision for outstanding claims.
  - Own facility cost for services to members using own facilities.
  - Claims settled in terms of risk transfer arrangements.
  - Charges for managed care: healthcare services (excluding risk transfer arrangements).
- .28 Payments may be made to third parties contracted to provide cost containment processes, such as specialist and hospital referrals, case management, peer reviews, claims audits, statistical analysis, and disease management (where healthcare service benefits are not included in the contract). These payments are separately disclosed as managed care: management service expenses. (Refer to paragraphs .31 to .33 of this guide.)
- .29 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.
- .30 The following are disclosed:
- Gross claims – current year.
  - Services provided to members in own facilities.
  - Movement in provision for outstanding claims for the year.
  - Savings plan claims paid and reported.
  - Managed care: healthcare services.

## **Managed care: management services expenses**

- .31 With the introduction of managed healthcare principles by medical schemes, medical schemes now incur expenses in applying these principles. Expenses may be incurred internally or services may be purchased from third parties. The principles are aimed at managing the use, cost and quality of healthcare services to the medical scheme.

- .32 Managed care: management services expenses are distinct from administration expenses and are therefore disclosed separately, splitting internal expenditure and outsourced costs. Managed care: management services costs are analysed to disclose the type of service rendered. Consideration should be given to related party relationships and transactions.
- .33 When items of income and expenses are material, their nature and amount shall be disclosed separately.

### **Own facility surplus or deficit**

- .34 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.
- .35 Income arising from making the medical scheme's own facilities available and rendering services to third parties is recognised on an accrual basis.
- .36 The calculation of the amount to be disclosed in the financial statements and includes:
- income for services rendered to third parties in own facilities to be reflected under other income; and
  - cost incurred in operating own facilities, less costs allocated to claims for services rendered to members in own facilities, to be reflected as other expenses.
- .37 Expenses included in operating own facilities are normally disclosed separately, for example, cost of sales, depreciation, lease rentals, etc.
- .38 Benefits (services) rendered by the own facility to the scheme's members are included in gross claims incurred as proportional share of costs incurred.

### **Broker service fees**

#### **Brokers' fees (acquisition costs paid to brokers and fees paid for ongoing services)**

- .39 A scheme may compensate a person, in accordance with its rules and the provisions of the Act and the regulations, for services provided to the scheme's members. Brokers' fees usually accrue and are paid on a monthly basis as 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 an insurer incurs to sell, underwrite and initiate a new insurance contract. Consideration should be given to related party relationships in transactions relating to brokers' fees.

### **Other distribution costs**

- .40 Distribution costs that are incurred under co-administration or other agreements are included under administration expenses in the income statement and are separately disclosed in the notes, unless those fees are paid to brokers. Where those distribution fees are paid to brokers, they are included as part of brokers' service fees.

### **Administration expenses**

- .41 In addition to the minimum disclosure on the face of the income statement in terms of IFRS, material income and expenses and income and expenses that are relevant to an understanding of the scheme's financial performance should be disclosed separately. 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.
  - Administration and consulting contracts with advisors to the members, which advisors are not the contracted medical scheme administrator.
  - Association fees.
  - Fees and disbursements to the auditors.
  - Fidelity guarantee and professional indemnity insurance premiums.
  - Marketing expenses.
  - Penalties.
  - Principal officer's fees.
- .42 Medical schemes are required to disclose any payment or consideration made to trustees in particular the following trustee costs either on the face of the income statement 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 of trustees.
  - Fees for attending meetings of the Board of Trustees or committees of the Board.
  - Fees due for holding a particular office on the Board or committees of the Board.
  - Fees for consultancy work performed for the medical schemes by a trustee.
  - Other remuneration paid to a trustee.
- .43 Administration costs recovered or recoverable from members and/or savings plan accounts are disclosed separately as part of other income.

### **Employee benefits**

- .44 The scheme should apply the requirements of IAS 19 – *Employee Benefits*, to all employee benefit plans.

### **Grants**

- .45 Where the medical scheme receives a grant from a sponsor, e.g. an employer, third party medical scheme administrator, etc., the grant may be shown separately in the income statement or as part of other operating income.

### **Outstanding claims provision**

- .46 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 savings plan accounts. The provision and its

movement, including an under or over provision of the previous accounting periods, are disclosed separately. (Refer to paragraphs .12 to .16 of this guide for further details on the liability adequacy test.)

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

- .47 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. Where cheques for claims have not been mailed, these cheques are added to the cash balance or deducted from the bank account borrowings, and included in trade and other payables.

### **Savings plans**

- .48 Some medical schemes provide for member savings plan 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.
- .49 Savings plan contributions are recognised on the accrual basis and withdrawals on the cash basis, i.e. no provision is made for outstanding claims at the end of the accounting period.
- .50 Unexpended savings at the end of the accounting period are carried forward to meet future expenses for which the members are responsible. The savings plan liability represents the savings plan contributions which are a deposit component of the insurance contracts. IFRS 4 allows, but does not require, the scheme to unbundle this deposit component. It is practice within the medical schemes industry to unbundle the deposit component and measure it separately because the savings plans are managed separately. The insurance component is measured under IFRS 4.
- .51 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 is not less than the amount payable on demand, discounted from the first date that the amount could be required to be paid. As a result the deposit component is measured at cost because it has a demand feature in that the contract that the member has with the medical scheme can be cancelled at any time. The demand feature is explained in Regulation 10 of the Act.
- .52 Depending on whether or not, in terms of the rules of the medical scheme, the medical scheme carries the risk relating to the savings plan, certain items may or may not be included in the savings plan liability. The determination as to whether the scheme or the savings account holder carries the risk needs to be disclosed. The following alternatives serve as explanations:
- The scheme carries the risk when all the surpluses and deficits on sale of investments relating to the savings plan are for the account of the scheme.
  - The savings account holder carries the risk when all surpluses and deficits on sale of investments relating to the savings plan are for the account of the savings account holder.
  - The scheme carries the risk of all impaired losses as a result of advances on savings plan accounts.
  - The saving account holder carries the risk of all impaired losses as a result of advances on savings plan accounts.

- .53 Where, in accordance with the rules of the medical scheme, the medical scheme carries the risk relating to savings plan accounts, any advances on savings plan accounts that are not recoverable are shown separately as part of impairment losses.
- .54 Where, in accordance with the rules of the scheme, the scheme does not carry the risk relating to the savings plan, gains or losses on re-measurement to fair value of investments relating to the savings plan, and profits or losses on sale of investments relating to the savings plan are allocated to the savings plan liability and disclosed separately in the savings plan liability note. Any advances on savings plan accounts that are not recoverable are also disclosed separately in the savings plan liability note.
- .55 This guide does not consider the impact of the trustees having discretion over the allocation of interest on the savings plan balance. Medical schemes would need to assess whether this amount is material in relation to the balance and whether it qualifies as a discretionary participation feature in terms of IFRS 4. (Refer to paragraphs 34 to 35 of IFRS 4 for further information.)

### **Related party disclosure**

- .56 Related party disclosure is discussed in detail in Appendices VI and VII. In terms of IAS 24 – *Related Party Disclosure*, a party is related to an entity if:
- (a) directly, or indirectly through one or more intermediaries, the party:
    - (i) controls, is controlled by, or is under common control with, the entity (this includes parents, subsidiaries and fellow subsidiaries);
    - (ii) has an interest in the entity that gives it significant influence over the entity; or
    - (iii) has joint control over the entity;
  - (b) the party is an associate (as defined in IAS 28 – *Investments in Associates*) of the entity;
  - (c) the party is a joint venture in which the entity is a venturer (see IAS 31 – *Interests in Joint Ventures*);
  - (d) the party is a member of the key management personnel of the entity or its parent;
  - (e) the party is a close member of the family of any individual referred to in (a) or (d);
  - (f) the party is an entity that is controlled, jointly controlled or significantly influenced by, or for which significant voting power in such entity resides with, directly or indirectly, any individual referred to in (d) or (e); or
  - (g) the party is a post-employment benefit plan for the benefit of employees of the entity, or of any entity that is a related party of the entity.

### **Guarantees received by the scheme from a third party**

- .57 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 is disclosed in the notes to the financial statements and the trustees' report. In terms of section 35(6) the medical scheme is not allowed to encumber its assets in support of such guarantee without the prior approval of the Registrar.

### **Solvency ratio**

- .58 Regulation 29 sets out the accumulated funds to be maintained by a medical scheme – the amount being determined as a percentage of gross annual contributions.

- .59 For the purpose of calculating the solvency ratio, the Act requires that:
- all unrealised net gains are to be excluded from the computation of accumulated funds (i.e. even if the surplus was credited/taken to income); and
  - gross annual contributions includes the annual contributions to members' savings accounts.

### **Road Accident Fund (RAF)**

- .60 A medical scheme may grant assistance to its members in defraying expenditure incurred in connection with 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 Act, 1996 (the RAFA). 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 scheme.
- .61 Receivables are raised for amounts contractually owing to the medical scheme at the balance sheet date. Note, however, that benefits paid by the RAF are not usually split between the medical and other costs; therefore the asset may not always be reliably measurable until such time as the scheme is notified of the amount to be paid over. For those receivables raised, the medical scheme should assess at each balance sheet date any objective evidence of impairment that has occurred that has an impact on the future estimated cash flows of the receivables. If any such evidence exists, the carrying amount of the accounts receivable should be reduced, either directly or through the use of a provision account, to its expected recoverable amount. The amount of the impairment loss shall be recognised in the income statement.
- .62 Recoveries from the RAF are reflected as part of other income in the income statement.

### **Surplus/(deficit) from operations per benefit option**

- .63 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 operating results of each benefit option under a medical scheme are therefore disclosed separately and the accounting records are maintained in such a way that the operating results for each benefit option can be determined. This information is usually disclosed as a note to the annual financial statements.

### **Standards and interpretations not yet effective**

- .64 The following table includes a list of standards/International Financial Reporting Interpretations Committee (IFRIC) interpretations/amendments to standards that have been issued up to 31 August 2006 and effective as indicated.

<b>Title</b>	<b>Type = Standard /IFRIC interpretation/ amendment to standard</b>	<b>Effective date – financial year commencing on or after ...</b>
IFRIC 7 – <i>Applying the Restatement Approach under IAS 29 - Financial Reporting in Hyperinflationary Economies</i>	New interpretation	1 March 2006
IFRIC 8 – <i>Scope of IFRS 2</i>	New interpretation	1 May 2006
IFRIC 9 – <i>Reassessment of Embedded Derivatives</i>	New interpretation	1 June 2006
AC 503 – <i>Accounting for Black Economic Empowerment (“BEE”) transactions</i>	New South African statement	1 May 2006
IFRS 7 – <i>Financial Instruments: Disclosures</i>	New standard	1 January 2007
<i>Consequential amendments to IAS 1 – Presentation of Financial Statements and IFRS 4 – Insurance Contracts</i>	Amendments to existing standards	1 January 2007
IFRIC interpretation 10 – <i>Interim financial reporting and impairment</i>	New interpretation	1 November 2006

#### Note

For all the new standards, interpretations and amendments listed above, the scheme must state whether they are applicable or not. For those which are applicable, the scheme must provide known or reasonably estimable information (i.e. quantification of the effect to the extent practicable) relevant to assessing the possible impact that the application of the new standard, interpretation or amendment will have on the scheme’s financial statements in the period of initial application. (For further detail see disclosure requirements as per IAS 8 paragraph 30.)

#### **Disclosures for financial instruments**

- .65 A new IFRS 7 – *Financial Instruments: Disclosure*, has been issued and is effective for annual periods beginning on or after 1 January 2007.
- .66 Medical schemes will need to accumulate the disclosure information required by this IFRS during the preparation of the financial statements for the year ended 31 December 2006 as this information will be required as comparative information in the financial statements prepared for the year ended 31 December 2007 when IFRS 7 will be first applied.
- .67 IFRS 7 deals with the disclosure requirements in relation to all risks arising from financial instruments (with limited exemptions), and applies to any scheme that holds financial instruments. The level of disclosure required depends on the extent of the scheme’s use of financial instruments and its exposure to financial risk.

- .68 The standard retains many of the disclosure requirements previously included in IAS 32 – *Financial Instruments: Presentation*, and IAS 30 – *Disclosure in the Financial Statements of Banks and Similar Financial Institutions*. In addition IFRS 7 makes editorial changes to the existing requirements and provides for additional disclosure requirements.
- .69 The overriding objective of the standard is that preparers should provide disclosures that enhance a user’s understanding of the scheme’s exposures to financial risks and how the scheme manages those risks.
- .70 To this end, the standard requires a scheme to disclose:
- information on the significance of financial instruments to the 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).
- .71 The most significant changes from the previous disclosure requirements include:
- A new requirement to disclose the carrying amounts of financial assets and financial liabilities under each of the classifications in IAS 39 (i.e. financial assets and financial liabilities designated as at fair value through profit or loss, held-to-maturity investments, loans and receivables, available-for-sale financial assets, and financial liabilities measured at amortised cost.
  - New disclosure requirements regarding loans and receivables designated as at fair value through profit or loss.
  - The extension of the requirement to disclose the fair value movement on financial liabilities designated as at fair value through profit or loss due to changes in credit risk to include loans and receivables designated as at fair value through profit or loss. In addition, schemes are required to disclose the method used to determine the amount of the change.
  - New disclosure requirements where there is a difference between the fair value of a financial instrument at initial recognition and the amount that would be determined at that date using a valuation technique (known as ‘day one profit or loss’). IFRS 7 requires disclosure of the scheme’s accounting policy for recognising that difference in the income statement, and the aggregate difference yet to be recognised in the income statement at the beginning and end of the period and a reconciliation of changes in the balance of this difference.
  - New disclosure requirements for financial assets that are either past due or impaired. IFRS 7 requires an analysis of the age of financial assets that are past due and, unless impracticable, an estimate of the fair value of collateral held by the scheme.
  - The disclosure of, for each class of financial asset, a reconciliation of changes in carrying amounts in that account during the period, where a scheme records an impairment on a financial asset or a group of financial assets through an allowance account (e.g. for bad debts), as opposed to a direct reduction to the carrying amount of the financial asset.
  - Separate disclosure of the amount of ineffectiveness recognised in the income statement on cash flow hedges and hedges of net investments in foreign operations.
  - Separate disclosure of the gains or losses in fair value hedges arising from re-measuring the hedging instrument and on the hedged item attributable to the hedged risk.

- Disclosure of the net gain or loss on ‘held-to-maturity investments’, ‘loans and receivables’ and ‘financial liabilities measured at amortised cost’.
- Additional requirements on providing sensitivity analysis of market risks and how changes in these risks would have impacted profit or loss and equity in the period.

.72 IAS 1 has also been amended as a result of IFRS 7. These amendments are effective for years beginning on or after 1 January 2007. The amendments to IAS 1 mainly relate to additional disclosures regarding the scheme’s objectives, policies and processes for managing capital. As a result of this amendment medical schemes would, amongst others, be required to disclose whether they have adhered to the regulatory capital requirements. 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.

### **New disclosures for insurance contracts**

.73 Certain changes have been made to IFRS 4 as a result of IFRS 7. These amendments to IFRS 4 will have to be applied in the financial statements prepared for the year ended 31 December 2007. Disclosure of comparative information is also required for this period. For this reason the information must already be collected for the 2006 financial year end.

.74 The consequential amendments to IFRS 4 mainly relate to the following:

- Previously an insurer was required to disclose information that helps users to understand the amount, timing and uncertainty of future cash flows from insurance contracts. According to the amendment, an insurer is required to disclose information that helps users to evaluate the nature and extent of risks arising from insurance contracts.
- Information about credit risk, liquidity risk and market risks is required by IFRS 4 to be provided as if the insurance contracts were within the scope of IFRS 7. Disclosure of information about interest rate risk is, however, no longer required for insurance contracts.
- The maturity analysis required by IFRS 7 may be replaced by disclosure of the estimated timing of the net cash outflows from the recognised insurance liabilities. Additional guidance is provided on how this disclosure requirement may be met.
- If an insurer uses an alternative method of managing sensitivity to market conditions, e.g. the embedded value analysis, such a method may be used to meet the requirements of IFRS 7 in this regard.

# REPORT OF THE BOARD OF TRUSTEES

- .01 In accordance with section 57(1) of the Act, every medical scheme is to have a Board of Trustees consisting of persons that are fit and proper to manage the business contemplated by the medical scheme in accordance with the applicable laws and the rules of the medical scheme.
- .02 At least 50% of the members of the Board of Trustees are to be elected from among the members of the medical scheme. A person shall not be a member of the Board of Trustees of a medical scheme, if that person is:
- an employee, director, officer, consultant or contractor of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator; or
  - a broker.
- .03 The duties and responsibilities of the Board of Trustees are set out in sections 57(4) and 57(6) of the Act. These include ensuring that proper registers, books and records of all operations of the medical scheme are kept, and that proper internal control systems are employed by or on behalf of the medical scheme.
- .04 In accordance with section 37(1) of the Act, the Board of Trustees is to cause annual 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 annual financial statements and therefore is not audited. However, consideration should be given to ISA 720 – *Other Information in Documents Containing Audited Financial Statements*.
- .05 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 the results thereof, and contain relevant information indicating whether or not the resources of the medical scheme have been applied economically, efficiently and effectively.
- .06 The report of the Board of Trustees is to be presented in such a way that it:
- 6.1 deals in narrative form with all descriptive matters under appropriate headings, and amounts or statistics are set out, as far as practicable, in tabular form and where any amounts are stated, the corresponding amounts, if any, in respect of the immediately preceding accounting period are stated;
  - 6.2 generally, reviews 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;
  - 6.3 addresses any material fact or circumstance that has occurred between the accounting date and the date of the report;
  - 6.4 where an actuarial service has been performed, states the nature of the service, the date of the service performed, the name of the actuary and his/her qualifications; and
  - 6.5 includes the following, unless such information is already given in any document annexed to the annual financial statements:

- 6.5.1 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.
- 6.5.2 The nature of the business of the medical scheme and any major change therein during the accounting period.
- 6.5.3 The basis and calculation of the solvency ratios; in this regard it is important to note that at no time should the solvency ratio be expressed as a percentage of contributions excluding savings contributions.
- 6.5.4 Any revaluation surplus and any other reserves set aside for a specific purpose and a description these reserves.
- 6.5.5 Any material disposals of the assets of the medical scheme during the accounting period that will have an impact on the future viability of the medical scheme.
- 6.5.6 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.
- 6.5.7 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.
- 6.5.8 Any interest that the medical scheme may have in any third party that manages the business of the medical scheme. A third party would include a professional administrator and/or provider of healthcare management services to the medical scheme.
- 6.5.9 Any interests that a trustee or the principal officer may have in any third party that manages the business of the medical scheme or any part thereof including the name of the trustee or principal officer, the contractual third party and the extent of the trustee's or principal officer's interest therein, if material. A third party would include a professional administrator and/or provider of healthcare management services to the medical scheme.
- 6.5.10 The names of the trustees and the principal officer, the principal officer's business address and any changes therein during the accounting period.
- 6.5.11 The nature, terms and conditions of any risk transfer arrangements, including the results of these agreements.
- 6.5.12 Minimum statistics for the current and comparative accounting period, as follows:
  - Average contributions per member and per beneficiary per month for the medical scheme as a whole and for each benefit option.

- Average claims per member and per beneficiary per month for the medical scheme as a whole and for each benefit option.
- Total claims as a percentage of gross contribution income.
- Average administration costs per member and per beneficiary per month for the medical scheme as a whole and for each benefit option.
- Amount paid to administrator.
- Non-health as a percentage of gross contribution income.
- Amount paid to brokers.
- Number of new members joining the scheme.
- Number of members leaving the scheme.
- Average accumulated funds per member at year-end.
- Dependant ratio to members at the end of the accounting period for the medical scheme as a whole and for each benefit option.
- Average number of members during the accounting period and number of members at the end of the accounting period.
- Average healthcare management expense per member and per beneficiary per month for the medical scheme as a whole and for each benefit option.
- Return on investments as a percentage of investments.

6.5.13 The basis for the outstanding claims provision, and whether or not the method is consistent with previous years.

- .07 The Board of Trustees report should include the attendance of Board of Trustee meetings and sub-committee meetings.
- .08 The Board of Trustees report should include the fact that savings contributions are refundable upon a member leaving the scheme or where a member transfers to an option within the scheme which does not have a savings-option, the money will be transferred to the member within six months of such a change taking place.
- .09 The Board of Trustees' report is to address the operations of the audit committee and other relevant committees, such as the investment committee and remuneration committee.
- .10 In terms of good corporate governance practices, annual financial statements are to include a responsibility statement by the Board of Trustees that addresses the following matters:
  - The trustees' responsibility for preparing annual 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 annual 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.
- That there is no reason to believe that the scheme will not be a going concern in the year ahead or an explanation of any reasons to believe otherwise.

# AUDITING GUIDE

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## Objectives

- .01 The objective of this section of the guide is to make auditors aware of the special factors to be considered in the audit of medical schemes. The guide is not intended to be comprehensive but rather to emphasise areas peculiar to the medical schemes industry. The guide assumes compliance with International Auditing Assurance and Ethics Pronouncements. This guide will not be sufficient on its own to provide all the detailed knowledge required by the auditor of a medical scheme in all the circumstances that might arise.

## The auditor's duty under the Act

- .02 The auditor of a medical scheme, amongst other responsibilities, has to report to members of the medical scheme on the financial statements in accordance with the Act and the regulations.
- .03 Section 36 of the Act deals with the appointment and reappointment of, and reporting by, the auditor. In accordance with section 36(2), the appointment and reappointment of the auditor has to be approved by the Registrar. Section 36(3) of the Act prohibits the appointment of certain persons as auditor.
- .04 The auditor's additional reporting responsibilities are set out in section 36(5) of the Act. The Act implies a material irregularity as defined in the Public Accountants' and Auditors' Act, 1991 (PAAA). The PAAA has been repealed by the Auditing Profession Act 2005, (APA) which replaces section 20(5) of the PAAA with a new section 45 dealing with reportable irregularities. Guidance on reporting a reportable irregularity can be found in the Independent Regulatory Board for Auditors' (IRBA) Guide, *Reportable Irregularities: A guide for Registered Auditors* (RI Guide). The additional reporting responsibilities per section 36(5) of the Act include the following:
- Whenever the auditor furnishes a report to the IRBA in terms of section 45 of the APA the auditor also has to furnish a copy thereof to the Registrar.
  - The auditor has to inform the Registrar in writing of any matter relating to the affairs of the medical scheme of which he/she became aware in the performance of his/her functions as auditor and which, in the opinion of the auditor, may prejudice the medical scheme's ability to comply with the requirements of Chapter 7 – *Financial Matters*, of the Act. Refer to the RI Guide for guidance on identifying and reporting a reportable irregularity and the effect thereof on the auditor's report.
  - If the auditor's appointment is terminated for any reason, including resignation, the auditor has to submit to the Registrar a statement of what the auditor believes to be the reasons for that termination and if the auditor would have had reason to submit a report as contemplated in terms of section 45 of the APA he/she should submit such a report to the Registrar. Refer to the RI Guide for guidance on reportable irregularities in light of the auditor's withdrawal from the audit engagement.
  - In addition to the above, the Registrar may request the auditor to furnish the Registrar with written information relating to any matter referred to in Chapter 7 of the Act.
- .05 The furnishing, in good faith, by an auditor of a report or information in terms of section 36(5) of the Act would not be deemed to constitute a contravention of a provision of a law or a breach of a provision of a code of professional conduct to which the auditor is subject. Furthermore, the failure, in good faith, by an auditor to furnish such report or information would not confer upon any person a right of action against the auditor which, but for that failure, that person would not have had.

- .06 In addition to the above, section 36(8) of the Act requires the auditor:
- in respect of a return or statement that the auditor is required to examine in terms of Chapter 7 of the Act, to certify whether or not that return or statement, including any annexure thereto, fairly presents the matters dealt with therein as if such return or statement were a financial statement contemplated in section 20 of the PAAA. The PAAA has been repealed by the APA which replaces section 20 of the PAA with a new section 44 dealing with duties in relation to audit; and
  - to carry out the other duties provided for in the Act and regulations.
- .07 Where the impact of non-compliance, considered in paragraph .06, is material, the auditor would highlight this in the audit report.

### **Compliance with laws and regulations**

- .08 In terms of ISA 250 – *Consideration of Laws and Regulations in an Audit of the Financial Statements*, when designing and performing audit procedures and in evaluating and reporting the results thereof, the auditor should recognise that non-compliance by the entity with laws and regulations may materially affect the financial statements. However, an audit cannot be expected to detect non-compliance with all laws and regulations.
- .09 As part of the audit procedures, the auditor should consider the medical scheme’s compliance, procedural and other obligations imposed by the Act, and rules of the medical scheme. The Council draws the attention of the auditor to the requirements regarding, whether:
- meeting requirements have been complied with;
  - decisions are properly minuted;
  - amendments to the rules have been registered in accordance with the Act, as amended, and regulations;
  - contribution rates and member benefits per benefit option as contained in the rules of the medical scheme have been registered and approved by the Registrar, and such approval has not been withdrawn;
  - financial guarantees have been received by the scheme from a third party, to ensure the financial soundness of benefit options, where required by the Registrar;
  - the scheme’s business has been maintained in a financially sound condition;
  - the scheme’s assets were invested in accordance with Regulation 30, read together with Annexure B of the Act;
  - failure for any period of 90 days to meet the solvency ratio required in terms of the regulations, has been reported to the Registrar in writing;
  - commercial reinsurance contracts have been furnished to the Office of the Registrar and the content of the contracts was to the satisfaction of the Registrar;
  - the Board of Trustees has appointed an audit committee, in accordance with section 36(10) of the Act, of at least five members of which at least two are members of the Board of Trustees and of which the majority are not officers of the medical scheme or the third party administrator, the controlling company of the administrator or any subsidiary of its controlling company, or exemption has been obtained in terms of section 36(13) of the Act;
  - annual financial statements, statutory reports and the trustees’ report have been submitted and not rejected by the Registrar;

- the medical scheme has not conducted any declared undesirable business practices; and
  - there has been compliance with all provisions relating to broker services and commission.
- .10 In particular, there may be laws and regulations, relating principally to the operating aspects of the medical scheme, that typically do not have a material effect on the financial statements and are not captured by the medical schemes' accounting and internal control information systems relevant to financial reporting. The auditor's report relates specifically to the financial statements and he/she may therefore not consider compliance with laws and regulations that do not have a financial statement impact.
- .11 The Council requires that the Board of Trustees include all areas of non-compliance with the Act in their report. The audit report does not cover the report of the Board of Trustees, however, the auditor would consider a modification of the audit report in terms of ISA 701–*Modifications to the Independent Auditor's Report*, where non-compliance with laws and regulations has a material effect on the financial statements.

### **Reportable irregularities**

- .12 In terms of section 45 of the APA, the auditor has a duty to report on irregularities to IRBA. Section 1 of the APA defines a reportable irregularity as:
- “any unlawful act or omission committed by any person responsible for the management of an entity, which:*
- (a) has caused or is likely to cause material financial loss to the entity or to any partner, member, shareholder, creditor or investor of the entity in respect of his, her or its dealings with the entity; or*
  - (b) is fraudulent or amounts to theft; or*
  - (c) represents a material breach of any fiduciary duty owed by such person to the entity or any partner, member, shareholder, creditor or investor of the entity under any law applying to the entity or the conduct or management thereof.”*
- .13 Registered auditors should refer to the RI Guide when considering reportable irregularities. The following points are of particular relevance:
- An unlawful act would be an act which is contrary to any law or regulations passed by government which applies to the entity, including the Act and regulations, or contrary to accepted common law practice. The APA does not introduce additional audit procedures to be performed for the purposes of detecting reportable irregularities and in the absence of these, the auditor reverts to the principle guidance contained in ISA including the requirements of ISA 250 – *Consideration of Laws and Regulations in an Audit of Financial Statements*.
  - “Any person responsible for the management of an entity” refers to senior management who carry sufficient responsibility for the entity and not only parts of the entity's activities but includes an act performed by any other employee with the knowledge or direction of management.
  - The measure of materiality should be applied in the context of absolute financial loss or within the context of the unlawful act or omission or breach of fiduciary duties, as applicable, and not the level of materiality for the purposes of the audit of financial statements.
  - Where third parties are contracted to discharge the responsibility of management of an entity, the parties contacted to manage the entity would also be parties responsible for the

management of the entity, for example in the case of an appointed medical scheme administrator.

- If the auditor is satisfied or has reason to believe that a reportable irregularity has taken place or is taking place in respect of the entity, he/she must, without delay, send a written report to IRBA. The reporting procedures and further actions by IRBA are set out in Part 2 of the RI Guide.

### **Reporting matters that may prejudice the medical scheme's ability to comply with the Act**

- .14 The auditor assesses the likelihood that transactions or conditions that may prejudice the medical scheme's ability to comply with the Act will be encountered during the audit of the financial statements.
- .15 These procedures do not constitute an extension of the scope of the audit of the financial statements, because the auditor does not change the nature, extent and timing of procedures performed during the audit.
- .16 The auditor, based on the knowledge of the medical scheme's business, assesses whether any transactions or conditions encountered during the audit of the financial statements are to be reported to the Registrar.
- .17 Such transactions or conditions include:
  - Transactions or conditions that necessitate a change in accounting basis, or require disclosure, because of doubts about the validity of the going concern assumption.
  - Other transactions or conditions giving rise to significant risks or exposures that have the potential to jeopardise the medical scheme's future ability to continue as a going concern, including speculative investment transactions, concentration of investment transactions in specific sectors of the economy, and insufficient segregation of duties resulting in an increase in risks.
  - Transactions or conditions indicating that the medical scheme has significant weaknesses in internal control that render it vulnerable to significant risks or exposures that have the potential to jeopardise the medical scheme's ability to continue as a going concern.
  - Transactions or conditions necessitating a modified audit opinion.
  - Transactions or conditions contravening solvency requirements.
- .18 It is important that the auditor not only assesses the significance of the individual transactions or conditions encountered, but also considers whether or not a combination of these items indicates the existence of transactions or conditions that are to be reported to the Registrar. The auditor discusses the findings with the appropriate levels of management, including the Board of Trustees and the audit committee.

### **Report of the Board of Trustees**

- .19 The report of the Board of Trustees does not form part of the financial statements and is unaudited. In terms of ISA 720 – *Other Information in Documents Containing Audited Financial Statements*, the auditor would read the report to identify material inconsistencies with the audited financial statements.

### **Information from managed care organisations**

- .20 Information obtained from managed care organisations is used in the financial statements of medical schemes. Registered auditors should consider ISA 402 – *Audit Considerations Relating to Entities Using Service Organisations*, where medical schemes make use of managed care organisations.
- .21 The auditor should decide whether the activities of a service organisation (such as a managed care organisation) are significant to the medical scheme. If significant the auditor should do a control risk assessment of the service organisation and conclude on the risk of material misstatement at both a financial statement level and at an assertion level. It follows that the reliability of information obtained from the managed care organisation should be assessed in light of the control environment at the service organisation and medical scheme.
- .22 It is important to determine whether the medical scheme or the managed care organisation is responsible for final authorisation of transactions and maintenance of accountability. Depending on the nature of this relationship, one of the following audit approaches towards the operating effectiveness of controls may be followed:
- Where the medical scheme maintains accountability*
- test the medical scheme’s controls over activities of the managed care organisation.
- Where the managed care organisation is accountable*
- obtain a third party audit report that expresses an opinion on the operating effectiveness of the managed care organisation’s internal controls that are relevant for the medical scheme; or
  - visit the managed care organisation and perform tests of controls.
- .23 The auditor reviews and assesses the conclusions drawn from the audit evidence obtained, including audit evidence obtained relating to information from managed care organisations, as a basis for expressing an opinion on the financial statements. The auditor may need to modify the audit report in terms of ISA 700 – *The Auditor’s Report on Financial Statements* where the necessary information is not available or cannot be relied on.

### **Reporting on summarised financial statements**

- .24 Medical schemes usually distribute summarised financial statements to their members and only provide the full set of financial statements on request. Registered auditors should refer to ISA 800 – *The Auditor’s Report on Special Purpose Audit Engagements*, where the summarised financial statements are prepared from audited financial statements.

### **Amalgamations**

- .25 The Council has highlighted the importance of ensuring that where schemes amalgamate, the balances (assets, liabilities and equity) taken forward by the remaining scheme should agree to the closing balances for the schemes that amalgamate. The auditor should consider the materiality of any differences and report accordingly.

### **Template reports**

- .26 Templates of the various reports applicable to auditors of medical schemes are available on the IRBA website ([www.irba.co.za](http://www.irba.co.za)).

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*These examples are intended mainly to illustrate some of the presentation and disclosure requirements of IFRS 4 and the Act. Reference should be made to the SAICA website ([www.saica.co.za](http://www.saica.co.za)) for links to complete sets of illustrative annual 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 IAS 32 would have required, had the insurance contracts been within the scope of IAS 32 (IFRS 4.(d)).*

*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.*

### **Income statement**

Schemes must prepare an income statement on a function or nature basis in terms of IAS 1. Schemes should be aware that the information provided in the financial statements should be reconcilable to the information in the statutory return.

### **Balance sheet**

Schemes should refer to IAS 1 in preparing a balance sheet. Schemes should be aware that the information provided in the financial statements should be reconcilable to the information in the statutory return.

### **Statement of changes in funds and reserves**

Schemes should refer to IAS 1 in preparing a statement of changes in funds and reserves. Schemes should be aware that the information provided in the financial statements should be reconcilable to the information in the statutory return.

### **Cash flow statement**

Schemes should refer to IAS 7 – *Cash Flow Statements* in preparing a cash flow statement. Schemes should be aware that the information provided in the financial statements should be reconcilable to the information in the statutory return.

## APPENDIX I

### EXTRACTS FROM THE PRINCIPAL ACCOUNTING POLICIES WHICH RELATE SPECIFICALLY TO MEDICAL SCHEMES

(Refer to paragraphs 36 to 39 and IG11 to IG 71 of IFRS 4 for specific items that should be addressed in the disclosure.)

#### **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.

#### **Contribution income**

Net contributions are received monthly. Net contributions represent gross contributions after deduction of savings plan contributions. The earned portion of net contributions received is recognised as revenue. Net contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. Net contributions are shown before the deduction of broker service fees and other similar costs.

#### **Claims**

Gross 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, whether or not reported by the end of the year.

Net claims incurred comprise:

- claims submitted and accrued for services rendered during the accounting period, net of recoveries from members for co-payments and savings plan accounts;
- movement in the provision for outstanding claims;
- own facility cost for services to members using own facilities;
- claims settled in terms of risk transfer arrangements; and
- charges for managed care: healthcare services (excluding risk transfer arrangements).

Claims incurred relating to risk transfer arrangements are calculated on the basis of [*insert basis of calculation*].

Anticipated recoveries under risk transfer arrangements are disclosed separately as assets and are assessed in a manner similar to the assessment of the outstanding claims provision and claims reported not yet paid.

#### **Outstanding claims**

Claims outstanding comprise provisions for the scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the balance-sheet date and related internal and external claims handling expenses. Claims outstanding 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 savings plan accounts are deducted in calculating the outstanding claims provision. The scheme does not discount its provision for outstanding claims, since the effect of the time value of money is not considered material.

## **APPENDIX I**

### **Savings plan liability**

The saving plan liability represents savings plan contributions which are a deposit component of the insurance contracts. The deposit component has been unbundled since the scheme can measure the deposit component separately and its accounting policies do not otherwise require it to recognise all obligations and rights arising from the deposit component. The insurance component is recognised in accordance with IFRS 4.

The saving plan liability, i.e. deposit component, is recognised in accordance with IAS 39 and is measured at cost because it has a demand feature. Savings plan contributions are credited on the accrual basis and withdrawals on a cash basis, i.e. no provision is made for outstanding claims at year end.

### **Liabilities and related assets under liability adequacy test**

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows, including related cash flows such as claims handling costs, and comparing this amount to the carrying value of the liability net of any related assets (i.e. the value of business acquired). Where a shortfall is identified, an additional provision is made and the scheme recognises the deficiency in income for the year.

### **Own facility**

The revenue 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 and sales related taxes. 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.

### **Risk transfer arrangements**

Risk transfer premiums/fees are recognised as an expense over the indemnity period on a straight-line basis. If applicable, a portion of risk transfer premiums/fees is treated as prepayments.

Risk transfer premiums/fees and benefits reimbursed are presented in the income statement and balance sheet on a gross basis. Only contracts that give rise to a significant transfer of insurance risk are accounted for as insurance. Amounts recoverable under such contracts are recognised in the same year as the related claim.

Claims recoveries relating to risk transfer arrangements are calculated on the basis of [*insert basis of calculation*].

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding claims provisions and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the outstanding claims provisions, claims reported not yet paid and settled claims associated with the risk transfer arrangement.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each balance sheet 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.

**APPENDIX I**

	<b>2006</b>	<b>2005</b>
	<b>R'000</b>	<b>R'000</b>
<b>TRADE AND OTHER RECEIVABLES</b>		
Contributions outstanding		
Recoveries from members for co-payments		
Savings plan account advances		
	<hr/>	
Less: provision for impairment losses		
Carrying amount at the beginning of the period		
Additional provisions made in the period (including increases to existing provisions)		
Amounts utilised during the period		
Unused amounts reversed during the period		
	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	
Prepaid expenses on risk transfer arrangements		
Other prepaid expenses		
Sundry accounts receivable [ <i>specify</i> ]		
Loans to members		
<b>Risk transfer arrangements</b>		
<i>Commercial reinsurance contracts</i>		
Share of outstanding claims provision		
Share of claims reported not yet paid		
Less: provision for impairment losses		
	<hr/>	
<i>Other risk transfer arrangements</i>		
Share of outstanding claims provision		
Share of claims reported not yet paid		
Less: provision for impairment losses		
	<hr/> <hr/>	

## APPENDIX I

	2006 R'000	2005 R'000
<b>TRADE AND OTHER RECEIVABLES (continued)</b>		
<b>Analysis of movements in respect of risk transfer arrangements</b>		
<i>Commercial reinsurance contracts</i>		
Balance at beginning of year		
Payments in respect of prior year		
Over/under provision in prior year		
Adjustment for current year		
Balance at end of year		
<i>Other risk transfer arrangements</i>		
Balance at beginning of year		
Payments in respect of prior year		
Over/under provision in prior year		
Adjustment for current year		
Balance at end of year		
<p>The carrying amounts of trade and other receivables approximate their fair values due to the short-term maturities of these assets.</p>		
<b>OUTSTANDING CLAIMS PROVISION</b>		
	<b>Covered by risk transfer arrangements</b>	<b>Not covered by risk transfer arrangements</b>
	<b>Commercial</b>	<b>Other</b>
<b>2006</b>		
Provision for outstanding claims – incurred but not yet reported		
Provision arising from liability adequacy test		

**APPENDIX I**

**OUTSTANDING CLAIMS  
PROVISION (CONTINUED)**

	Covered by risk transfer arrangements		Not covered by risk transfer arrangements
	Commercial	Other	
<b>2006</b>			
<b>Analysis of movements in outstanding claims</b>			
Balance at beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment for current year			
Balance at end of year			
<b>Analysis of movements in provision arising from liability adequacy test</b>			
Balance at beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment for current year			
Balance at end of year			
<b>Analysis of outstanding claims provision</b>			
Estimated gross claims			
Outstanding claims provision relating to risk transfer arrangement			
Less: estimated recoveries from			
co-payments			
savings plan accounts			
Balance at end of year			

**APPENDIX I**

**OUTSTANDING CLAIMS  
PROVISION (CONTINUED)**

	Covered by risk transfer arrangements		Not covered by risk transfer arrangements
	Commercial	Other	
<b>2005</b>			
Provision for outstanding claims – incurred but not yet reported			
Provision arising from liability adequacy test			
<hr/> <hr/>			
<b>Analysis of movements in outstanding claims</b>			
Balance at beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment for current year			
Balance at end of year			
<hr/> <hr/>			
<b>Analysis of movements in provision arising from liability adequacy test</b>			
Balance at beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment for current year			
Balance at end of year			
<hr/> <hr/>			
<b>Analysis of outstanding claims provision</b>			
Estimated gross claims			
Outstanding claims provision relating to risk transfer arrangement			
Less: estimated recoveries from co-payments			
savings plan accounts			
Balance at end of year			
<hr/> <hr/>			

## APPENDIX I

### OUTSTANDING CLAIMS PROVISION (CONTINUED)

	Covered by risk transfer arrangements		Not covered by risk transfer arrangements
	Commercial	Other	
2005			
<b>Net exposure in respect of outstanding claims</b>			
Gross outstanding claims (see above)			
Less: estimated recoveries from risk transfer arrangements			
Net outstanding claims			

*For illustrative purposes we have used two alternatives. 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 between schemes. Schemes should consider obtaining input from their actuaries and consultants in compiling this note. Refer to paragraphs 36 to 39 and IG11 to IG 71 of IFRS 4 for specific items that should be addressed in the disclosure.*

#### Alternative 1

##### Process used to determine the assumptions

The process used to determine the assumptions is intended to result in neutral estimates of the most likely or expected outcome. The sources of data used as inputs for the assumptions are internal, using detailed studies that are carried out annually. There is more emphasis on current trends, and where in early years there is insufficient information to make a reliable best estimate of claims development, prudent assumptions are used.

Each notified claim is assessed on a separate, case-by-case basis with due regard to the claim circumstances, information available from managed care: management services and historical evidence of the size of similar claims. The provisions are on the basis of information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate costs of the loss is difficult to estimate. The provision estimation difficulties also differ by category of claims (i.e. in-hospital, chronic and above threshold benefits) caused by differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, the determination of the occurrence date of a claim, and reporting lags.

The cost of outstanding claims is estimated using the [XXX] model. This model extrapolates the development of paid and incurred claims, average cost per claims and ultimate claim numbers for each benefit year based upon observed development of earlier years and expected loss ratios. Run off triangles are used in situations where it takes time after the treatment date for the full extent of the claims to become known. It is assumed that payments will emerge in a similar way in each service month. The proportional increase in the known cumulative payments from one development month to the next can then be used to calculate payments for future development months.

## APPENDIX I

### **Process used to determine the assumptions (continued)**

The actual method or blend of methods used varies according to benefit year being considered, categories of claims and observed historical claims development. To the extent that these methods use historical claims development information they assume that the historical claims development pattern will occur again in the future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include *[this list is not exhaustive]*:

- changes in processes that affect the development/recording of claims paid and incurred (such as changes in claim reserving procedures);
- economic, legal, political and social trends (resulting in different than expected levels of inflation and/or minimum medical benefits to be provided);
- changes in composition of members and their dependants; and
- random fluctuations, including the impact of large losses.

### **Assumptions**

The assumptions that have the greatest effect on the measurement of the outstanding 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 claims provisions for the 2006 and 2005 benefit years. The expected claims ratio assumed for the benefit years 2006 and 2005 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 to particular 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 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 balance sheet is adequate. However, it recognises that the process of estimation is based upon certain variables and assumptions which could differ when claims arise.

## APPENDIX I

### Impact on reported profits caused by changes in key variables

	Change in variable	Change in liability 2006 R'000	Change in liability 2005 R'000
In-hospital claims ratio	%		
Chronic claims ratio			
Above Threshold benefit claims ratio			
Inflation			
Manual claims as percentage of total claims			

This analysis is prepared for a change in a specified variable with other assumptions remaining constant.

### Alternative 2

#### Process used to determine the assumptions

The process used to determine the assumptions is intended to result in a 90% level of assurance of the outcome. The sources of data used as inputs for the assumptions are a combination of annual detailed internal studies and industry statistics published by ABC Statistics. More emphasis is placed on current trends.

Each notified claim is assessed on a separate, case by case basis with due regard to the claim circumstances, information available from managed care: management services and historical evidence of the size of similar claims. The provisions are based on information currently available. However, the ultimate liabilities may vary as a result of subsequent developments. The impact of many of the items affecting the ultimate costs of the loss is difficult to estimate. The provision estimation difficulties also differ by category of claims (i.e. in-hospital, chronic and above threshold benefits) caused by differences in the underlying insurance contract, claim complexity, the volume of claims, the individual severity of claims, the determination of the occurrence date of a claim, and reporting lags.

Members have to submit all claims for payment within four months of seeking medical treatment. The cost of outstanding claims at the reporting date is, in this way estimated with reference to the actual claims submitted within the first three months after the reporting date that relates to the period before the reporting date. The claims to be submitted in the fourth month, relating to the reporting period, are then extrapolated with the XXX model.

The above methods use historical claims development information and assume that the historical claims development pattern will occur again in the future. There are reasons why this may not be the case, which, insofar as they can be identified, have been allowed for by modifying the methods. Such reasons include [*this list is not exhaustive*]:

- changes in processes that affect the development/recording of claims paid and incurred (such as changes in claim reserving procedures);
- economic, political and social trends (resulting in different than expected levels of inflation and/or minimum medical benefits to be provided);
- changes in composition of members and their dependants;
- random fluctuations, including the impact of large losses; and
- changes in the relevant legislation, e.g. the Medical Scheme Act.

## APPENDIX I

### Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding claims provision are the average cumulative claims ratios per benefit option for the most recent benefit year. The cumulative claims ratios per benefit option for the most recent benefit year are:

Benefit option A: XX%

Benefit option B: XX%

Benefit option C: XX%

Benefit option D: XX%

These assumptions have changed since the previous reporting period. Refer below for more information.

The assumptions that have the greatest effect on the measurement of the recoveries that will be made under risk transfer arrangements, which relate to the outstanding claims provision, are the cumulative claims ratios per category of benefits provided for the most recent benefit years. The cumulative claims ratios per category of benefits provided are as follows:

in-hospital benefits: XX% (2005: XX%)

chronic disease benefits: XX% (2005: XX%)

pharmaceutical: XX% (2005: XX%)

radiology: XX% (2005: XX%)

### Changes in assumptions and sensitivities to changes in key variables

Previously the measurement of the outstanding claims provision has been based on the average cumulative claims ratios for the scheme as a whole for the most recent benefit year. The calculation has been refined and is now based on the average cumulative claims ratios per benefit option for the most recent benefit year. Applying the refined assumptions lead to a decrease of Rxxx in the outstanding claims provision at the reporting date.

The table below outlines the sensitivity of insured liability estimates to particular 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 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 balance sheet is adequate. However, it recognises that the process of estimation is based on certain variables and assumptions which could differ when claims arise.

## APPENDIX I

### Impact on reported profits caused by changes in key variables

	Change in variable	Change in liability	Change in liability
	%	2006 R'000	2005 R'000
In-hospital benefits: XX% (2005: XX%)	XX	XX	NA
Chronic disease benefits: XX% (2005: XX%)	XX	XX	NA
Pharmaceutical: XX% (2005: XX%)	XX	XX	NA
Radiology: XX% (2005: XX%)	XX	XX	NA
Average claims ratio for the scheme		NA	XX

### SAVINGS PLAN LIABILITY

	2006 R'000	2005 R'000
<b>Where, in terms of the rules of the medical scheme, the medical scheme carries the risk</b>		
Balance on savings plan liability at the beginning of the year [ <i>credit balances</i> ]		
Less: Advances on savings plan accounts [ <i>shown under trade and other receivables</i> ]		
Prior-year adjustment [ <i>where applicable – refer to full disclosure in terms of IAS 8</i> ]		
Balance on savings plan liability at the beginning of the year [ <i>net balances</i> ]		
Add:		
Savings plan account contributions received or receivable		
For the current year		
Received in advance		
Allocated to settle prior-year advances		
Transfers from other schemes [ <i>distinguishing between amalgamations and other transfers</i> ]		
Interest paid on savings plan accounts		
Advances on savings plan accounts [ <i>to be shown under trade and other receivables</i> ]		
Less:		
Claims paid on behalf of members		
Administration expenses [ <i>to be deducted from the administration expenses of the medical scheme, i.e. to be shown as a recovery by the medical scheme of administration expenses incurred on behalf of the savings plan</i> ]		
Refunds on death or resignation		
Transfers to other schemes		
Balances due to members on savings plan accounts at the end of the year [ <i>credit balances only</i> ]		

## APPENDIX I

	2006 R'000	2005 R'000
<b>SAVINGS PLAN LIABILITY (CONTINUED)</b>		
<b>Where, in terms of the rules of the medical scheme, the medical scheme does not carry the risk</b>		
Balance on savings plan liability at the beginning of the year		
Less:		
Prior-year adjustment [ <i>where applicable – refer to full disclosure in terms of IAS 8</i> ]		
Adjusted balance on savings plan liability at the beginning of the year		
Add:		
Savings plan account contributions received or receivable		
For the current year		
Received in advance		
Allocated to settle prior-year advances		
Interest paid on savings plan accounts		
Gains/(losses) on re-measurement to fair value of investments relating to savings plan		
Surpluses/(deficits) on disposal of investments relating to savings plan		
Transfers from other schemes [ <i>distinguishing between amalgamations and other transfers</i> ]		
Other income [ <i>to be specified</i> ]		
Less:		
Claims paid on behalf of members		
Impairment losses incurred		
Administration expenses [ <i>to be deducted from the administration expenses of the medical scheme, i.e. to be shown as a recovery by the medical scheme of administration expenses incurred on behalf of the savings plan</i> ]		
Other expenses [ <i>to be specified</i> ]		
Less:		
Refunds on death or resignation		
Transfer to other schemes		
Balance on savings plan liability at the end of the year		

In accordance with the rules of the scheme, the savings plan is underwritten by the scheme.

The savings plan liability contains a demand feature in terms of Regulation 10 of the Medical Schemes 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.

**APPENDIX I**

**SAVINGS PLAN LIABILITY (CONTINUED)**

It is estimated that claims to be paid out of members' savings accounts in respect of claims incurred in 2006 but not recorded amount to RXX (2005: RXX). Advances on savings plan accounts are included in trade and other receivables.

**TRADE AND OTHER PAYABLES**

	<b>2006</b>	<b>2005</b>
	<b>R'000</b>	<b>R'000</b>
Net contributions received in advance		
Reported claims not yet paid		
Payments in advance under risk transfer arrangements		
Other payables and accrued expenses		
Post retirement benefits		
Current portion of non-current borrowings		

The carrying amounts of trade and other payables approximate their fair values because of the short-term maturities of these liabilities.

**Reported claims not yet paid**

Balance at beginning of year	
Movements for year [ <i>specify</i> ]	_____
Balance at end of year	_____

**NET CONTRIBUTION INCOME**

Gross contributions	
Less:	
Savings contributions	
Net contribution income	_____
	_____

**NET CLAIMS INCURRED**

**Claims incurred excluding claims incurred in respect of risk transfer arrangements.**

Current-year claims	
Services provided to members in own facilities	
Movement in outstanding claims provision	
Over/under provision in prior year	_____
Adjustment for current year	
Movement in provision arising from liability adequacy test	
Over/under provision in prior year	_____
Adjustment for current year	
Claims paid/charged to savings accounts	
Managed care: healthcare services	_____
	_____

**APPENDIX I**

	<b>2006 R'000</b>	<b>2005 R'000</b>
<b>NET CLAIMS INCURRED (CONTINUED)</b>		
<b>Claims incurred in respect of related risk transfer arrangements</b>		
Current-year claims incurred in respect of related risk transfer arrangements		
Movement in outstanding claims provision		
Over/under provision in prior year		
Adjustment for current year		
Movement in provision arising from liability adequacy test		
Over/under provision in prior year		
Adjustment for current year		
Net claims incurred per the income statement		
<b>NET INCOME/(EXPENSE) ON RISK TRANSFER ARRANGEMENTS</b>		
Claims incurred in respect of related risk transfer arrangements		
Premiums/fees paid		
Recoveries received		
Net income/(expense) on risk transfer arrangements		

## APPENDIX I

	2006 R'000	2005 R'000
<b>MANAGED CARE: MANAGEMENT SERVICES</b>		
Provider service account review		
Specialist, hospital referrals and pre-authorisations		
Case management		
Disease management		
HIV management		
Pharmacy benefit management		
Disease/prescribed minimum benefit management		
Clinical auditing		
Drug utilisation review		
Eternity Asthma Programme		
Female wellness programme		
Fraud hotline		
Managed hospital care		
Managed health services, ambulance and helpline		
Hospital pre-authorisation		
Maternity management		
Medical advisors		
Member counselling, compliance monitoring & risk assessment		
Member health portal		
Mental health programme		
Mothers-to-be programme		
Oncology utilisation management		
One-care PMB management fee		
Optical management		
Provider profiling		
Stress-line		
Utilisation review		
<b>BROKER SERVICE FEES</b>		
Brokers' fees		
Other distribution costs paid to brokers		

## APPENDIX I

### TRUSTEES' REMUNERATION AND CONSIDERATIONS \*

	Fees for meeting attendance R'000	Fees for holding of office R'000	Fees for consultancy services R'000	Allowances R'000	Total remuneration R'000	Training R'000	Conference fees R'000	Travel and accommodation R'000	Other disbursements and reimbursements R'000	Total considerations R'000
<b>2006</b>										
Trustee 1										
Trustee 2										
Trustee 3										
Trustee 4										
Total										
<b>2005</b>										
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.]



## APPENDIX I

### 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. Principle features of the benefit options are as follows:

- ACB Comprehensive Option [*insert detail*]
- ACB 70/100 Option [*insert detail*]
- ACB Major Events Option [*insert detail*]

	ACB Comprehensive Option R'000	ACB 70/100 Option R'000	ACB Major Events Option R'000	Total scheme R'000
<b>2006</b>				
<i>[Insert line items per income statement]</i>				
<b>2005</b>				
<i>[Insert line items per income statement]</i>				

### CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

*This illustrative note only addresses areas of critical accounting judgement and areas of key sources of estimation uncertainty to the extent that it relates to insurance contracts.*

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 in applying the scheme's accounting policies:  
*[provide details]*

Key assumptions concerning the future and other key sources of estimation uncertainty at the balance-sheet 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 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.

## APPENDIX I

### INSURANCE RISK MANAGEMENT

#### **Risk-management objectives and policies for mitigating insurance risk (Alternative 1)**

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. These risks relate 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 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.

The scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. These methods include internal risk-measurement models, sensitivity analyses, scenario analyses and stress testing. 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.

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.

#### **2006**

<b>Age grouping (in years)</b>		<b>In-hospital</b>		<b>Chronic</b>		<b>Day-to-day</b>	<b>Total</b>
		<b>PMB</b>	<b>Non-PMB</b>	<b>PMB</b>	<b>Non-PMB</b>		
		<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>
< 26	Gross						
	Net						
26 – 35	Gross						
	Net						
36 – 50	Gross						
	Net						
51 – 65	Gross						
	Net						
>65	Gross						
	Net						
Total	Gross						
	Net						

## APPENDIX I

### INSURANCE RISK MANAGEMENT (CONTINUED)

2005

Age grouping (in years)		In-hospital		Chronic		Day-to-day	Total
		PMB R'000	Non- PMB R'000	PMB R'000	Non- PMB R'000	R'000	R'000
< 26	Gross						
	Net						
26 – 35	Gross						
	Net						
36 – 50	Gross						
	Net						
51 – 65	Gross						
	Net						
>65	Gross						
	Net						
Total	Gross						
	Net						

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.

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 this reduces the variability of the outcome.

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 contracts at renewal. Management information including contribution income and claims ratios by option, target market and demographic split, is reviewed monthly. There is also an underwriting review programme that reviews a sample of contracts on a quarterly basis to ensure adherence to the scheme's objectives.

#### **Risk-management objectives and policies for mitigating insurance risk (Alternative 2)**

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. These risks relate 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.

## APPENDIX I

### INSURANCE RISK MANAGEMENT (CONTINUED)

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 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 about 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 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.

**2006**

Age grouping (in years)		General practitioners	Specialists	Dentistry	Optometry	Medicines	Hospital	Total
		R'000	R'000	R'000	R'000	R'000	R'000	R'000
< 26	Gross							
	Net							
26 – 35	Gross							
	Net							
36 – 50	Gross							
	Net							
51 – 65	Gross							
	Net							
>65	Gross							
	Net							
Total	Gross							
	Net							

## APPENDIX I

### INSURANCE RISK MANAGEMENT (CONTINUED)

2005

Age grouping (in years)		General practitioners	Specialists	Dentistry	Optometry	Medicines	Hospital	Total
		R'000	R'000	R'000	R'000	R'000	R'000	R'000
< 26	Gross							
	Net							
26 – 35	Gross							
	Net							
36 – 50	Gross							
	Net							
51 – 65	Gross							
	Net							
>65	Gross							
	Net							
Total	Gross							
	Net							

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.

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 this reduces the variability of the outcome.

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 including contribution income and claims ratios by option, target market and demographic split, is reviewed monthly. There is also an underwriting review programme that reviews a sample of contracts on a quarterly basis to ensure adherence to the scheme's objectives.

## **APPENDIX I**

### **INSURANCE RISK MANAGEMENT (CONTINUED)**

#### **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 buys a combination of proportional and non-proportional commercial reinsurance contracts to reduce the net exposure to the scheme to Rxxx. 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 under various agreements that cover individual risks, group risks or defined blocks of business, on a co-insurance, yearly renewable term, excess or catastrophe excess basis. These risk transfer arrangements spread the risk and minimise the effect of losses. The amount of each risk retained depends on the scheme's evaluation of the specific risk, subject in certain circumstances, to maximum limits on the basis of characteristics of coverage. According to the terms of the risk transfer arrangements, the third party agrees to reimburse the ceded amount in the event the claim is paid. According to the terms of the capitation agreements, the suppliers provide certain minimum benefits to all scheme members, as and when required by the members. The scheme does, however, remain liable to its members with respect to ceded insurance if any reinsurer (or supplier) fails to meet the obligations it assumes.

When selecting a reinsurer (or supplier) the scheme considers its relative security. The security of the reinsurer (or supplier) is assessed from public rating information and from internal investigations [*such as considering capital adequacy, solvency, capacity and appropriate resources*].

#### **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.]*

## APPENDIX II

### COMMON PROBLEM AREAS IDENTIFIED BY THE COUNCIL FOR MEDICAL SCHEMES

During the annual return analysis in May 2006, the Council identified certain common problem areas regarding the application/implementation of IFRS. These problem areas are listed below, to assist the schemes in the preparation of the 31 December 2006 financial statements. Items such as the treatment of capitation agreements and related party disclosures, which have been addressed in detail in the guide and other appendices, have been excluded from the list.

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

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

#### **Accounting policies**

Several schemes included irrelevant accounting policies in their financial statements. The following extract from paragraphs 108 and 110 of IAS 1 may assist schemes in this regard:

*“An entity shall disclose in the summary of significant accounting policies:*

- a) the measurement basis (or bases) used in preparing the financial statements; and*
- b) the other accounting policies used that are relevant to an understanding of the financial statements.*

*In deciding whether a particular accounting policy should be disclosed, management considers whether disclosure would assist users in understanding how transactions, other events and conditions are reflected in the reported financial performance and financial position. Disclosure of particular accounting policies is especially useful to users when those policies are selected from alternatives allowed in standards and interpretations.”*

#### **Offsetting**

The Council wants to bring paragraph 32 and 33 from IAS 1 to the attention of schemes regarding offset:

*“Assets and liabilities, and income and expenses, shall not be offset unless required or permitted by a standard or an interpretation.*

*It is important that assets and liabilities, and income and expenses, are reported separately. Offsetting in the income statement or the balance sheet, except when offsetting reflects the substance of the transaction or event, detracts from the ability of users both to understand the transactions, other events and conditions that have occurred and to assess the entity’s future cash flows. Measuring assets net of valuation allowances such as obsolescence allowances on inventories and doubtful debts allowances on receivables, is not offsetting”.*

The offsetting of fees paid to asset managers against investment income (for e.g. interest received) is not allowed in terms of IAS 1.

Off-setting of operating expenses on the rental of investment property (other than the initial direct costs incurred in negotiating and arranging the related operating lease) against investment income is not in terms of IAS 1 and therefore these expenses and income should be shown separately.

## APPENDIX II

### **Materiality of income and expenses**

The Council wants to bring to the schemes' attention paragraph 29 from IAS 1, which clearly indicates that material amounts should be disclosed separately.

*“When items of income and expenses are material, their nature and amount shall be disclosed separately.”*

### **Income statement, balance sheet and statement of changes in funds and reserves (minimum disclosure requirements)**

Schemes are reminded to comply with IAS 1, to meet the minimum disclosure requirements for the income statement, balance sheet and statement of changes in funds and reserves.

Notice should be taken of the requirement of IAS 1 to present additional line items, headings and subtotal on the face of the income statement when such a presentation is relevant to an understanding of the scheme's financial performance.

### **Interest paid and received on savings account balances**

Interest paid on savings accounts must be disclosed separately. Schemes should also take into consideration the criteria for “off-setting” (refer to above).

### **Administration fees reimbursements**

In instances where the administrator has reimbursed a portion of the administration fees paid by the schemes, offsetting should not take place and the amount should be disclosed as part of income.

Over or under payments of the administration fees should be adjusted against the administration expenses.

### **Financial instruments**

#### ***Available for sale investments***

*According to IAS 39.55(b) “A gain or loss on an available-for-sale financial asset shall be recognised directly in equity, through the statement of changes in equity... except for impairment losses ... and foreign exchange gains and losses ..., until the financial asset is derecognised, at which time the cumulative gain or loss previously recognised in equity shall be recognised in profit or loss. However, interest calculated using the effective interest method ... is recognised in profit or loss .... Dividends on available-for-sale equity instruments are recognised in profit or loss when the scheme's right to receive payment is established.”*

Schemes should recognise the portion of the available-for-sale reserve that is realised upon the disposal of the available-for-sale investment in the income statement.

Schemes should make arrangements with their investment managers to ensure that they receive the information that is required for compliance with IAS 32 and IAS 39.

#### ***Unrealised and realised gains and losses***

A scheme shall disclose material items of income, expense and gains and losses resulting from financial assets and financial liabilities, whether included in the income statement or as a separate component of equity. For this purpose, the disclosure shall include at least the following items:

- Total interest income and total interest expense (calculated using the effective interest method) for financial assets and financial liabilities that are not at fair value through profit or loss.

## APPENDIX II

- For available-for-sale financial assets, the amount of any gain or loss recognised directly in equity during the period and the amount that was removed from equity and recognised in the income statement for the period.
- The amount of interest income accrued on impaired financial assets, in accordance with IAS 39, AG93.

### **Trade and other receivables**

Schemes should assess the accuracy of the age analysis of their trade and other receivable as this may impact the calculation of the impairment loss.

The Council want to refer the schemes to IAS 39 paragraph 63 and AG 84 to 92 of IAS39 for more information.

The process for estimating impairment considers all credit exposures, not only those of low credit quality. For example, if a scheme uses an internal credit grading system it considers all credit grades, not only those reflecting a severe credit deterioration.

For the purpose of a collective evaluation of impairment, financial assets are grouped on the basis of similar credit risk characteristics that are indicative of the debtor's ability to pay all amounts due according to the contractual terms (for example on the basis of a credit risk evaluation or grading process that considers asset type, industry, geographical location, collateral type, past-due status and other relevant factors).

Impairment losses recognised on a group basis represent an interim step pending the identification of impairment losses on individual assets in the group of financial assets that are collectively assessed for impairment. As soon as information is available that specifically identifies losses on individually impaired assets in a group, those assets are removed from the group.

### **Incorrect classification of receivables with credit balances**

A number of instances were noted where schemes disclosed individual receivables with credit balances as receivables and payables with debit balances as payables. Schemes should ensure correct classification by reclassifying these receivables and payables.

### **Provision for impairment losses**

In a number of incidents the Council found that the movement in the provision for impairment losses as per the notes to the balance sheet, when recalculated, could not be agreed to the movement in the provision for impairment losses reflected in the income statement. Schemes should ensure that the provision for impairment losses is both reasonable and accurately reflected in the annual financial statements.

### **Wash-sale transactions**

The Council noticed there were schemes which entered into "wash-sale transactions". All transactions should be accounted for in terms of IFRS in order for the scheme to be IFRS-compliant.

*Please take note that each transaction and situation should be evaluated and considered individually; the situation stated below is an example and treatment is only applicable to this example.*

Inconsistent accounting treatments were noted in respect of the repurchase of financial assets shortly after sale. If a financial asset is repurchased shortly after sale, it can only be derecognised if it meets the derecognition criteria of IAS 39. However, if an agreement to sell a financial asset is entered into concurrently with an agreement to repurchase the same asset at a fixed price or the sale price plus a lender's return, criteria for derecognition may not be met, in which case the financial asset should not be derecognised.

## **APPENDIX II**

Schemes should refer to IAS 39, Appendix A, AG 51(e) and IAS 39 paragraphs 17 to 20 and consider the derecognition criteria before accounting for financial assets as being disposed off. The appendix to IAS 39 also gives examples to illustrate the application of the derecognition principles of the standard.

### **Risk management report**

Schemes are reminded that they should ensure compliance with IAS 32 and IFRS 4 when disclosing the Risk Management Report. The Council would like to refer schemes to IFRS 4 paragraphs 38 to 39. The disclosure requirements of IAS 32 will be replaced with IFRS 7 which is applicable for years commencing on or after 1 January 2007.

Council encourages the disclosure of a liquidity risk analysis, although it is not compulsory in terms of IAS 32. This will be required disclosure in terms of IFRS 7.

Schemes should also note that there is a difference between the interest rate risk analysis and the liquidity risk analysis.

The risk management report should be tailored to the specific risk management procedures of the scheme.

## APPENDIX III

### ILLUSTRATIVE REPORT OF THE BOARD OF TRUSTEES

#### ACB MEDICAL SCHEME

The Board of Trustees hereby presents its report for the year ended 31 December 2006.

Registration Number: 1992/00111/94

#### 1 DESCRIPTION OF THE MEDICAL SCHEME

##### 1.1 Terms of registration

The ACB Medical Scheme is a not for profit open medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), as amended. In terms of the registration, a guarantee has been issued by PQR Bank in favour of ACB Medical Scheme and lodged with the Registrar.

##### 1.2 Benefit options within the ACB Medical Scheme

The medical scheme offers three benefit options to employers and members of the public. These are:

- ACB Comprehensive;
- ACB 70/100; and
- ACB Major Events.

*[The trustees may wish to amplify the business of the scheme by providing more details.]*

##### 1.3 Savings plan

In order to provide a facility for medical scheme members to set funds aside to meet future healthcare costs not covered in the benefit options, the trustees have made the savings plan option available to meet this objective.

Members that belong to the ACB Major Events and the ACB 70/100 benefit options pay an agreed sum of XX% and XX% respectively of their gross contributions into a savings account so as to help pay the members' portion of healthcare costs, up to a prescribed threshold.

Unexpended savings amounts are accumulated for the long-term benefit of the member and interest is paid on balances at the same rate as the PQR Bank pays on 12-month fixed deposits from time to time. Interest is charged on savings advanced to members.

The liability to the members in respect of the savings plan is reflected as a financial liability in the financial statements, repayable in terms of Regulation 10 of the Act.

In terms of the rules of the medical scheme, the medical scheme carries the risk.

## APPENDIX III

### 1 DESCRIPTION OF THE MEDICAL SCHEME (continued)

#### 1.4 Risk transfer arrangements

The scheme has reinsured certain risks with XYZ International Reinsurance Ltd to protect the medical scheme from any unusual exposure to high cost incidence claims.

The scheme has also entered into a capitation agreement with MNO Hospital to provide services for the duration of the year.

### 2 MANAGEMENT

#### 2.1 Board of Trustees in office during the year under review

AB Flowers	Chairman (member trustee)	
EF Jackson	Employer trustee	
GH Lemson	Member trustee	Appointed 1 April 2006
IJ Mahlangu	Employer trustee	
KL Naidoo	Member trustee	Resigned 31 March 2006
RS Peterson	Trade union representative (member trustee)	
OP van Os	Independent consultant	
MN Pillay	Trade union representative (member trustee)	

#### 2.2 Principal Officer

CD Irish Professional Principal Officer Ltd Professional House 1 Rivonia Drive Rivonia Sandton 2128	P O Box 1 Rivonia 2128
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#### 2.3 Registered office address and postal address

C/o Scheme Administrators Ltd Medical Schemes House 575 Rivonia Drive Rivonia Sandton 2128	P O Box 2375 Rivonia 2128
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#### 2.4 Medical scheme administrator during the year

Scheme Administrators Ltd Medical Schemes House 575 Rivonia Drive Rivonia 2128	P O Box 2375 Rivonia 2128
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## APPENDIX III

### 2 MANAGEMENT (continued)

#### 2.5 Investment managers during the year

PQR Investment Bank Ltd PQR Bank Chambers Diagonal Street Johannesburg 2001	P O Box 34567 Johannesburg 2002
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#### 2.6 Investment advisors during the year

Investo Bank Ltd Smith Street Johannesburg 2001	P O Box 842135 Johannesburg 2001
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#### 2.7 Actuaries

ABS Actuaries ABS House Jorrison Street Braamfontein 2000	P O Box 68451 Johannesburg 2002
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#### 2.8 Auditors

EFG Auditors Fredman Drive Sandton 2128	P O Box 159 Sandton 2128
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### 3 INVESTMENT STRATEGY OF THE MEDICAL SCHEME

*[Investment strategies are scheme specific but the following examples illustrate the type of disclosure that should be made. Schemes may wish to include matters of non-compliance with Regulation 30, read together with Annexure B, under this heading.]*

The scheme's investment objectives are to maximise the return on its investments on a long term basis at minimal risk. The investment strategy takes into consideration both constraints imposed by legislation and those imposed by the Board of Trustees. *[Provide details on the nature of the investments.]*

The investment committee met four times during 2006. The mandate of the committee is to ensure that:

- the scheme remains liquid;
- investments are placed at minimum risk and the best possible rate of return;
- investments made are in compliance with the regulations of the Act; and
- a risk assessment is performed with feedback to the Board of Trustees with recommendations on the risks identified.

## APPENDIX III

### 3 INVESTMENT STRATEGY OF THE MEDICAL SCHEME (continued)

The scheme invested in fixed deposits, bonds and cash instruments during 2006. This investment policy is reviewed annually, taking into consideration compliance with the Act, the risk and returns of the various investment instruments and the surplus of funds available.

During the year the Board recognised that the investment climate was changing and decided that there was a need to review the policy of investing mainly in money market investments. An investment committee was formed and it was agreed that an investment advisor should be appointed with a view to funds being channelled into more appropriate areas. The advisor's primary mandate is to comply with prevailing legislative constraints and to ensure value retention while still ensuring growth. The funds are currently managed passively but it is the intention of the Board of Trustees to pursue an active management policy and to consider the appointment of fund managers.

### 4 REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

#### 4.1 Operational statistics

	ACB Compre- hensive Option	ACB 70/100 Option	ACB Major Events Option	Total Scheme
<b>2006</b>				
Average net contributions per member per month				
Average net contributions per beneficiary per month				
Claims as a percentage of gross contributions				
Average administration costs per member per month				
Average administration cost per beneficiary per month				
Amounts paid to administrator				
Non-health expenses as a percentage of gross contributions				
Number of new members				
Number of members leaving scheme				
Average number of members during the year				
Number of members at 31 December				
Average accumulated funds per member				

## APPENDIX III

	<b>ACB Compre- hensive Option</b>	<b>ACB 70/100 Option</b>	<b>ACB Major Events Option</b>	<b>Total Scheme</b>
<b>2006</b>				
Dependant ratio to members at 31 December				
Average healthcare management expense per member per month				
Average healthcare management expense per beneficiary per month				
Return on investments as a percentage of investments				
<b>2005</b>				
Average net contributions per member per month				
Average net contributions per beneficiary per month				
Claims as a percentage of gross contributions				
Average administration costs per member per month				
Average administration cost per beneficiary per month				
Amounts paid to administrator				
Non-health expenses as a percentage of gross contributions				
Number of new members				
Number of members leaving scheme				
Average number of members during the year				
Number of members a 31 December				
Average accumulated funds per member				
Dependant ratio to members at 31 December				
Average healthcare management expense per member per month				
Average healthcare management expense per beneficiary per month				
Return on investments as a percentage of investments				

## APPENDIX III

### 4.2 Results of operations

The results of the medical scheme are set out in the annual financial statements, and the trustees believe that no further clarification is required.

### 4.3 Solvency ratio

	2006 R'000	2005 R'000
Total members' funds per balance sheet		
Less:		
Revaluation reserve		
Cumulative net gains on re-measurement to fair value of financial instruments and property, plant and equipment included in the accumulated funds **		
Funds set aside for specific purposes		
Specific assets encumbered for third party liabilities		
Add:		
Subordinated loan as approved by the Council		
Accumulated funds per Regulation 29		
Gross contributions		
	%	%
Solvency ratio		
** Cumulative net gains on remeasurement to fair value are calculated as follows:		
Net cumulative gains opening balance at the beginning of the period		
Less:		
Opening balance of revaluation reserve transferred to accumulated funds (IAS 39 – <i>Financial Instruments: Recognition and Measurement</i> transition adjustment)		
Impairment losses and reversal of impairment losses on remeasurement to fair value of financial instruments and investment properties included in accumulated funds		
Add:		
Movement in unrealised gains/(losses) on remeasurement to fair value of financial instruments and investment properties included in accumulated funds		
Movement in realisation of cumulative gains/(losses) recognised in the accumulated funds on remeasurement at disposal of financial instruments		
<b>Cumulative net gain on remeasurement to fair value of properties and investments included in accumulated funds</b>		

## APPENDIX III

### 4.4 Reserve accounts

Movements in the reserves are set out in the Statement of Changes in Funds and Reserves. There have been no unusual movements that the trustees believe should be brought to the attention of the members of the medical scheme.

### 4.5 Outstanding claims

The basis of calculation of the outstanding claims provision is discussed in [*insert note number*] and this is consistent with the prior year. Movements on the outstanding claims provision are set out in [*insert note number*] to the annual financial statements. There have been no unusual movements that the trustees believe should be brought to the attention of the members of the medical scheme.

## 5 ACTUARIAL SERVICES

The scheme's actuaries have been consulted in the determination of the contribution and benefit levels.

## 6 GUARANTEES RECEIVED BY THE SCHEME FROM A THIRD PARTY

In terms of section 33(3) of the Medical Schemes Act, PQR Bank has provided a guarantee of RXX (2005: RXX) to the scheme.

## 7 POST BALANCE SHEET EVENTS

[*Provide details*]

## 8 INVESTMENTS IN AND LOANS TO PARTICIPATING EMPLOYERS OF MEMBERS OF THE MEDICAL SCHEME AND TO OTHER RELATED PARTIES

The medical scheme holds no investments in participating employers of medical scheme members.

The medical scheme has made an investment in the XYZ Day Hospital (Pty) Ltd in Johannesburg, which forms part of a provider network established by the trustees to serve a large number of members resident in Johannesburg. The cost of the share investment is R1m, and represents 7% of the issued share capital of XYZ Day Hospital (Pty) Ltd.

Scheme Administrators Ltd, which is the contracted administrator of the medical scheme, has a significant influence on the management and operation of the medical scheme. Payments are made in terms of the administration agreement and the broker's agreement with Scheme Administrators Ltd and, during the 2005 financial year, were as follows:

Administration fees for own facilities	RXX	(2005: R XX)
Administration fees for medical scheme	RXX	(2005: R XX)
Brokers' fees	RXX	(2005: R XX)

## 9 AUDIT COMMITTEE

An audit committee was established in accordance with the provisions of the Act. The committee is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. The committee consists of five members of which two are members of the Board of Trustees. The majority of the members, including the chairperson, are not officers of the medical scheme or of its third party administrator. The committee met on four occasions during the course of the year and these meetings were attended by all members.

## **APPENDIX III**

The chairperson of the medical scheme, the financial manager, the external auditors and the internal auditor attend all audit committee meetings and have unrestricted access to the chairperson of the committee.

In accordance with the provisions of the Act, the primary responsibility of the committee is to assist the Board of Trustees in carrying out its duties relating to the medical scheme's accounting policies, internal control systems and financial reporting practices. The external auditors formally report to the committee on critical findings arising from audit activities.

The committee presently comprises: JB Corner, ST Hudson (chairperson), JB Loggs, EF Jackson and GH Lemson.

### **10 INVESTMENT COMMITTEE**

An investment committee was established and is mandated by the Board of Trustees by means of written terms of reference as to its membership, authority and duties. This committee consists of five members of which two are members of the Board of Trustees. The majority of the members, including the chairperson, are not officers of the medical scheme or its third party administrator. The committee met on four occasions during the course of the year and these meetings were attended by all members.

The chairperson of the medical scheme and the financial manager attend all investment committee meetings and have unrestricted access to the chairperson of the committee.

The primary responsibility of the committee is to assist the Board of Trustees in carrying out its duties relating to the investment policy of the scheme.

The committee presently comprises: OP van Os (chairperson), IJ Mahlangu, T Rudolph and C Games.

## APPENDIX III

### 11 TRUSTEE MEETING ATTENDANCE AND REMUNERATION

The following schedule sets out Board of Trustees meeting attendances. Trustee remuneration is disclosed in [insert note number] to the annual financial statements.

Trustee/sub-committee member	Board meetings		Executive Committee meetings		Finance Committee meetings		Investment Committee meetings		Audit Committee meetings	
	A	B	A	B	A	B	A	B	A	B
JB Loggs										
JB Corner										
C Games										
AB Flowers										
ST Hudson										
EF Jackson										
GH Lemson										
IJ Mahlangu										
KL Naidoo										
RS Peterson										
OP van Os										
T Rudolph										

A – total possible number of meetings could have attended

B – actual number of meetings attended

### 12 SUB-COMMITTEE MEETING ATTENDANCE

The following schedule sets out meeting attendances by members of Board sub-committees. Trustee remuneration is disclosed in [insert note number] to the annual financial statements.

Trustee/sub-committee member	Board meetings		Executive Committee meetings		Finance Committee meetings		Investment Committee meetings		Audit Committee meetings	
	A	B	A	B	A	B	A	B	A	B
JB Loggs										
JB Corner										
C Games										
ST Hudson										
EF Jackson										
GH Lemson										
IJ Mahlangu										
OP van Os										
T Rudolph										

A – total possible number of meetings could have attended

B – actual number of meetings attended

### 13 NON-COMPLIANCE WITH THE ACT

The following area of non-compliance with the Act was identified during the course of the financial year: Contravention of Regulation 30, Annexure B, Category 3(a)(i). The allowable limit of 2.5% per single property has been exceeded by 1.8%. This non-compliance matter will be addressed within the following six months by disposing of the excess properties which have resulted in the scheme exceeding the allowable limit of 2.5%.

## APPENDIX IV

### IFRS 4 – *INSURANCE CONTRACTS*

#### **Objective**

- .01 The objective of IFRS 4 – *Insurance Contracts* is to specify the financial reporting for insurance contracts by any entity that issues such contracts until the International Accounting Standards Board (IASB) completes the second phase of its project on insurance contracts. In particular, IFRS 4 requires:
- limited improvements to accounting by insurers for insurance contracts; and
  - disclosure that identifies and explains the amounts in an insurer's financial statements arising from insurance contracts and helps users of those financial statements understand the amount, timing and uncertainty of future cash flows from insurance contracts.

#### **Scope**

- .02 A medical scheme shall apply IFRS 4 to all insurance contracts that it issues and risk transfer arrangements that it holds. For ease of reference, IFRS 4 and this section of the guide describe any entity that issues an insurance contract as an insurer, even though a medical scheme is not regarded as an insurer for legal or supervisory purposes.
- .03 A risk transfer arrangement is a type of insurance contract. Accordingly, all references in IFRS 4 and this guide to insurance contracts also apply to risk transfer arrangements (reinsurance contracts as defined in IFRS 4).

#### **The extent of applying IFRS 4**

- .04 A medical scheme will need to ascertain to what extent it is exposed to the requirements of IFRS 4. In order to make this assessment, a medical scheme will have to complete the following process:
- Step 1:** Determine to what extent contracts issued by the medical scheme meet the definition of an insurance contract.
- Step 2:** In the event that the medical scheme does issue insurance contracts and are therefore deemed to be an insurer for IFRS 4 purposes, determine to what extent contracts that it holds meet the definition of a risk transfer arrangement.
- Step 3:** Ensure that the medical scheme's accounting policies adhere to minimum recognition and measurement requirements of IFRS 4.
- Step 4:** Provide disclosure in the financial statements that identifies and explains the amounts in the medical scheme's financial statements arising from insurance contracts (and risk transfer arrangements held) and helps users of those financial statements understand the amount, timing and uncertainty of future cash flows from insurance contracts (and risk transfer arrangements held).

Each step in the process is discussed in more detail below.

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### Step 1: Definition of an insurance contract

.05 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.”*

.06 Some fixed-fee service contracts in which the level of service depends on an uncertain event meet the definition of an insurance contract in IFRS 4 but are not regulated as insurance contracts in some countries. Thus, the legal definition of an insurance contract might preclude some contracts that meet the definition of insurance contracts for IFRS 4 purposes.

.07 In order to apply the definition of an insurance contract to a contract issued by a medical scheme, the following aspects of the definition need to be considered carefully:

- *The term “uncertain future event”*

An uncertain future event is the event that is covered by an insurance contract and results in insurance risk (refer below). The uncertainty (or risk) is the essence of an insurance contract. Accordingly, at least one of the following needs to be uncertain at the inception of an insurance contract:

- Whether an insured event will occur (*for example*: there is uncertainty whether the member will seek medical treatment);
- When it will occur (*for example*: there is uncertainty when the member will seek medical treatment); or
- How much the insurer will need to pay if the event occurs (*for example*: how much will be payable by the medical scheme if the member seeks medical treatment).

- *Payments in kind*

Some insurance contracts (and risk transfer arrangements) require or permit payments to be made in kind. An example is when an insurer uses its own hospitals and medical staff to provide medical services covered by the insurance contracts. This method of settlement does not preclude a contract from being classified as an insurance contract.

- *Insurance risk and other risks*

The definition of an insurance contract refers to insurance risk, which IFRS 4 defines as risk, other than financial risk, transferred from the holder of a contract to the issuer. A contract that exposes the issuer to financial risk without significant insurance risk is not an insurance contract. IFRS 4, Appendix A, defines what risks are classified as financial risk.

The definition of insurance risk refers to risk that the insurer accepts from the policyholder (i.e. the member). In other words, insurance risk is a pre-existing risk transferred from the policyholder to the insurer. Thus, a new risk created by the contract is not insurance risk.

Some contracts require a payment if a specified uncertain event occurs, but do not require an adverse effect on the policyholder as a precondition for payment. Such a contract is not an insurance contract even if the holder uses the contract to mitigate an underlying risk exposure.

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- *Significant insurance risk*

A contract is an insurance contract only if it transfers significant insurance risk. Insurance risk is significant if, and only if, an insured event could cause an insurer to pay significant additional benefits in any scenario.

Scenarios that lack commercial substance (i.e. have no discernible effect on the economics of the transaction) are excluded from the analysis.

If significant additional benefits would be payable in scenarios that have commercial substance, the condition may be met even if the occurrence of the insured event under the scenarios is extremely unlikely.

An insurer shall assess the significance of insurance risk contract by contract, rather than by reference to materiality to the financial statements.

Quantitative guidance creates an arbitrary dividing line that results in different accounting treatments for similar transactions that fall marginally on different sides of the line. It also creates opportunities for accounting arbitrage by encouraging transactions that fall marginally on one side or the other of the line. For these reasons, IFRS 4 does not include quantitative guidance on what “significant” is.

- *Changes in the level of insurance risk*

A contract that qualifies as an insurance contract remains an insurance contract until all rights and obligations are extinguished or expire.

(Refer to Illustrative Example 1 in IFRS 4 for more guidance.)

### **Step 2: Risk transfer arrangements held**

- .08 A risk transfer arrangement is defined by IFRS 4 as an insurance contract issued by one insurer (the reinsurer) to compensate another insurer (the cedant) for losses on one or more contracts issued by the cedant.
- .09 Therefore, a contract held by a medical scheme will meet the definition of a risk transfer arrangement in terms of IFRS 4 if:
- The contract meets the definition of an insurance contract; and
  - The reinsurer compensates the medical scheme for losses on insurance contracts issued to members.
- .10 The first criterion has been discussed under Step 1. The remainder of the discussion will assume that the first criterion has been met and will therefore focus on how the reinsurer compensates the insurer (i.e. the medical scheme) for losses on insurance contracts issued to members.
- .11 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 managed health care arrangement (capitation agreement) whereby the provider is paid a monthly sum or capitation fee to provide defined services, during a specified period, according to the needs of a predetermined member group of the scheme. The provider carries the risk of the number of incidents that occur during the specified period and the cost of providing the service.

## APPENDIX IV

- .12 As with insurance contracts, it is important to note that some fixed-fee service contracts in which the level of service depends on an uncertain event meet the definition of a risk transfer arrangement in IFRS 4 but are not regulated as risk transfer arrangements in some countries. Thus, the legal definition of reinsurance might preclude some contracts that meet the definition of reinsurance contracts for IFRS 4 purposes.
- .13 In the event where a medical scheme enters into a commercial reinsurance contract, in terms of which it transfers some or all of its risk to a legally registered reinsurer, it is fairly easy to assess whether the second criterion has been met. In this instance, the reinsurer will generally compensate the medical scheme in cash for losses incurred.
- .14 Where the medical scheme enters into a capitation agreement with a provider (e.g. a hospital group) to provide medical services to a pre-determined member group, it becomes more difficult to assess whether the second criterion has been met. In this instance the provider does not compensate the medical scheme in cash. In order to complete the assessment, the following two questions need to be addressed:

- *Does the medical scheme still incur losses on insurance contracts issued to members where the insurance risks are covered by a provider in terms of a capitation agreement?*

Regulation 15A of the Act states: “If a medical scheme provides benefits to its beneficiaries by means of a managed health care arrangement with another person –

- *the terms of that arrangement must be clearly set out in a written contract between the parties;*
- *with effect from 1 January 2005, such arrangement must be with a person who has been granted accreditation as a managed health care organisation by the Council; and*
- *such arrangement must not absolve a medical scheme from its responsibility towards its members if any other party to the arrangement is in default with regard to the provision of any service in terms of such arrangement.”*

A capitation agreement, therefore, cannot absolve a medical scheme from its exposure towards its members. In substance, the medical scheme still incurs losses on insurance contracts issued to members even though the insurance risks are covered by a provider in terms of a capitation agreement. The medical scheme is still exposed to the insurance risk covered by the contract with its member.

For example: Where a medical scheme provides in-hospital benefits to a member and enters into a capitation agreement with a hospital-group to provide specified medical care at any one of its hospitals to the member, the medical scheme still has the legal obligation to settle any costs incurred by the member while in hospital. The capitation agreement cannot absolve that obligation or responsibility.

- *How does the provider compensate the medical scheme for the losses incurred?*

As stated above, the provider does not compensate the medical scheme in cash i.e. the medical scheme does not settle the medical expenses incurred by the member and then receive a cash refund from the provider. Instead, the provider compensates the medical scheme for the losses incurred (in terms of its existing obligation to its member) by providing the medical benefits directly to the member at no cost. In substance, the provider compensates the medical scheme in kind for the losses it incurred. As discussed under Step 1, this method of settlement does not preclude a contract from being classified as a risk transfer arrangement.

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### Step 3: Recognition and measurement

- .15 Paragraphs 10 to 12 of IAS 8 specify criteria for an entity to use in developing an accounting policy if no IFRS applies specifically to an item. However, IFRS 4 exempts an insurer from applying those criteria to its accounting policies regarding insurance contracts. Therefore, an insurer can continue to apply its current accounting policies to insurance contracts issued and risk transfer arrangements held.
- .16 Nevertheless, IFRS 4 does not exempt an insurer from some implications of the criteria in paragraphs 10 to 12 of IAS 8. Specifically, an insurer:
- shall not recognise as a liability any provisions for possible future claims, if those claims arise under insurance contracts that are not in existence at the reporting date;
  - shall carry out the liability adequacy test (for more guidance, please refer to paragraphs .12 to .16 of the accounting guide);
  - shall remove an insurance liability (or a part of an insurance liability) from its balance sheet when, and only when, it is extinguished, i.e. when the obligation specified in the contract is discharged or cancelled or expires;
  - shall not offset:
    - risk transfer assets against the related insurance liabilities; or
    - income or expense from risk transfer arrangements against the expense or income from the related insurance contracts; and
  - shall consider whether its assets relating to risk transfer arrangements are impaired (for more guidance, please refer to IFRS 4 paragraph 20).

### Step 4: Disclosure

- .17 An insurer shall disclose information that identifies and explains the amounts in its financial statements arising from insurance contracts. An insurer shall also disclose information that helps users to understand the amount, timing and uncertainty of future cash flows from insurance contracts. (Refer to IFRS 4, Illustrative Example 3, for more guidance.)

### Accounting for capitation agreements

- .18 In the event that a capitation agreement meets the definition of a reinsurance agreement, IFRS 4 states that an insurer shall not offset risk transfer assets against the related insurance liabilities or income or expense from risk transfer arrangements against the expense or income from the related insurance contracts and shall consider whether its risk transfer assets are impaired.
- .19 Therefore, a medical scheme will account for the components of capitation agreements as follows:
- *Capitation fee*

The fixed fee (capitation fee) is a risk transfer premium and has to be disclosed separately as an expense from a risk transfer contact. The journal will be:

Dr. Capitation fee (I/S)  
Cr. Cash (B/S)
  - *Exposure to member vs. recovery in kind from provider*

The cost the medical scheme would have incurred (had it not entered into the capitation agreement) to deliver the specified benefits firstly represents the medical scheme's exposure to its member (as the capitation agreement cannot absolve a medical scheme

## APPENDIX IV

from its responsibility towards its members). This “cost” has to be disclosed as claims incurred from insurance contracts.

The “cost” the medical scheme would have incurred (had it not entered into the capitation agreement) to deliver the specified benefits secondly represents the medical scheme’s recovery in kind from the managed health care provider. This recovery in kind of cost incurred has to be disclosed as recoveries from risk transfer arrangements.

It must be noted that the medical scheme incurs the costs simultaneously as the managed healthcare provider provides the services to the member. Therefore, if there is no dispute regarding the costs covered by the capitation agreement, the claims incurred by the medical scheme are settled in kind instantly by the service provider. However, in terms of IFRS 4 this income (recoveries) and expense (claims from members) should be disclosed separately. This will result in a gross-up in the income statement.

The journal will be:

Dr. Claims incurred (I/S)  
Cr. Recovery under risk transfer arrangements (I/S)

Depending on the tail of the specified benefits provided and the timing and accuracy of information received from the managed healthcare provider regarding the specified benefits delivered before year end; the medical scheme should recognise an IBNR liability and a risk transfer asset. This represents the medical scheme’s best estimate of costs incurred and “costs” recovered in kind before year-end, but not yet reported at that time.

In terms of IFRS 4 these assets (recoveries) and liabilities (claims from members) should be disclosed separately and cannot be set-off as the capitation agreement cannot absolve a medical scheme from its responsibility towards its members. This will therefore result in a gross-up in the balance sheet.

The journals will be:

Dr. Claims incurred (I/S)  
Cr. IBNR provision (B/S)

Dr. Recovery under risk transfer arrangements (B/S)  
Cr. Recovery under risk transfer arrangements (I/S)

To the extent that further information is received after balance-sheet date and it is certain that all obligations to members have been settled in kind by the service provider, the IBNR provision (liability) and the risk transfer recovery (asset) are derecognised.

The journal will be:

Dr. IBNR provision (B/S)  
Cr. Recovery under risk transfer arrangements (B/S)

- *Impairment of assets under risk transfer arrangement*

A medical scheme should consider its risk transfer assets for impairment at balance-sheet date. An asset under a capitation agreement 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 recover its full exposure in kind in terms of the

## **APPENDIX IV**

contract; and that the event has a reliably measurable impact on the amounts that the scheme will now have to pay to the member.

The journal will be:

Dr. Impairment loss (I/S)

Cr. Recovery under risk transfer arrangements (B/S)

(Please refer to Illustrative Example 2 in appendix V for more guidance.)

## APPENDIX V

### CAPITATION AGREEMENTS ILLUSTRATIVE EXAMPLES

#### Example 1: 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:

Consideration	Application
(a) Identify the insured event.	The insured event is costs incurred by the member while he is in hospital.
(b) Establish if the insured event affects the insured adversely.	The insured event will affect the member adversely as he will have to pay the costs incurred.
(c) Identify the scenario in which the insured event occurs.	The costs can be incurred at any stage within the term of the contract.
(d) Establish if (c) has commercial substance (i.e. does it have a discernable effect on the economics of the transaction).	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).
(e) Determine the amount payable by the insurer under (c).	The amount payable under the scenario in (c) is the costs incurred by the member while in hospital up to an overall annual limit.
(f) Determine another scenario in which the insured event does not occur.	The contract expires without any insured event happening.
(g) Establish if (f) also has commercial substance (i.e. does it have a discernable effect on the economics of the transaction).	Yes, the scenario in (f) does have commercial substance; otherwise ABC Medical Scheme couldn't offer the benefits in a manner that is commercially viable for it, i.e. it is commercially viable that the member wouldn't claim over the contract period.
(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.

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### Example 2: Simple capitation agreement, without a profit/loss sharing mechanism

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

#### Background

##### *Journal 1*

A medical scheme (“A”) entered into a fixed fee capitation agreement with a managed care organisation (“B”). B provides medical care through a series of clinics. In terms of the agreement, B agrees to provide specified medical care at any one of its clinics to the members of A at no cost to the member. The total capitation fee paid to B was R50 000.

##### *Journal 2*

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.)

##### *Journal 3 and 4*

A member of A was admitted to one of B’s clinics on 27 December 2006 for medical care covered by the capitation agreement. The member of A was discharged from the clinic on 5 January 2007. 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 2007.

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 2006.

A’s best estimate at year end of costs it would have incurred to provide the ten days medical care to its members not yet reported to it by 31 December 2006 is R8 000. A does not expect any dispute with B regarding estimated medical cover provided by B to a member of A.

##### *Journal 5 and 6*

On 10 January 2007, A receives the information from B and confirmation that its estimate as at year-end was incorrect.

##### *Journal 7*

On 10 January 2007 A also receives confirmation that the claim of R10 000 from a member was settled in kind by B under the capitation agreement.

How does A account for the capitation agreement and related claims transactions?

#### Suggested solution

Journal 1: A would account for the capitation fee as follows:

Dr. Capitation fee (I/S)	50 000	
Cr. Bank (B/S)		50 000

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Journal 2: A would account for the claims incurred in terms of the capitation agreement with B as follows:

Dr Claims (I/S)	70 000	
Cr Claims recoveries (I/S)		70 000 (claims settled)

Simultaneously A also incurred a claim of R10 000 ( $R20\,000 * 5/10$  days) on 31 December 2006 from its member, which was only reported on 10 January 2007.

Journal 3: On 31 December 2006 A was not aware of the incurred expense, and therefore recognised an IBNR provision based on its best estimate of costs it would have incurred to provide the ten days medical care to its members not yet reported to A by 31 December 2006. 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 Provision (B/S)		8 000

In substance, A also incurred a recovery of R10 000 ( $R20\,000 * 5/10$  days) on 31 December 2006 from B, which was only reported on 10 January 2007;

Journal 4: On 31 December 2006 A was not aware of the incurred income, and therefore recognised a risk transfer recovery provision 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 2006. This represents the costs A would not be held accountable for in terms of its obligation to its member due to B settling the claim 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

Journals 5 and 6: On 10 January 2007, 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: On 10 January 2007 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

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The effect of the transaction on the note disclosure for the IBNR provision will be as follows:

<b>IBNR Provision</b>	<b>2007</b>	<b>2006</b>
Opening balance	8 000	XXX
Claims settled	(10 000)	XXX
Changes to estimates recognised in profit or loss	2 000	XXX
Claims raised	XXX	8 000
Closing balance	XXX	8 000

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 management accounts (assuming that they are prepared before 10 January 2007) the above entries would be represented as follows:

Claims incurred	
Claims paid by scheme	XXX XXX
Claims settled	70 000
IBNR	8000
Risk transfer arrangements (capitation agreement)	
Premiums/fees paid	50 000
Claims settled	(70 000)
IBNR	(8000)
Total claims	<u>XXX XXX</u>

The 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.)

## APPENDIX VI

### RELATED PARTY DISCLOSURES

#### Who are potential related parties to a medical scheme?

- .01 Each medical scheme needs to assess individually who its related parties are, taking into account their individual circumstances. 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*:

Party	IAS 24.9	Other considerations
1. Board of Trustees	Consider part d) of definition.	
2. Principal Officer (PO)	Consider part d) of definition.	
3. Members of executive committee/financial managers/ Chief Executive Officer etc.	Consider part d) of definition.	
4. Close family members of individuals identified in 1,2 and 3	Consider part e) of definition.	Specifically consider independent family members.
5. An entity that is: <ul style="list-style-type: none"> <li>• Controlled;</li> <li>• Jointly controlled; or</li> <li>• Significantly influenced by any individual in point 1, 2, 3 and 4.</li> </ul>	Consider part f) of definition.	
6. Subsidiaries, associates and joint ventures of scheme	Consider part a), b) and c) of definition.	
7. Employer groups	Consider part a (ii) of definition.	Employer group could have significant influence – consider the following: <ul style="list-style-type: none"> <li>• Does the employer exert control over the scheme through restrictions for example on benefit types, or contribution increases?</li> <li>• Has the scheme been set up exclusively for the benefit of an employer’s employees?</li> <li>• Are increases in membership fees and changes in benefits dependent on an agreement between the scheme and key management personnel of the employer group?</li> <li>• What is the employer’s ability</li> </ul>

## APPENDIX VI

Party	IAS 24.9	Other considerations
		to appoint trustees? <ul style="list-style-type: none"> <li>What is the membership proportion of an employer?</li> </ul>
8. Administrators	Consider part a (ii) of definition.	Administrators may not control a scheme (section 57(3) of the Act.). They could however have significant influence – consider the following: <ul style="list-style-type: none"> <li>Does the administrator have a strong influence over directing the scheme? Does this translate into participation in the policy decision making process?</li> <li>Does the administrator provide key management information and access to key resources which enables the Board of Trustees to make decisions?</li> <li>Are the trustees effective in directing the scheme, or is there heavy reliance on administrators for guidance and advice.</li> </ul>
9. Managed care organizations	Consider part a (ii) of definition.	Do the services provided constitute provision of essential technical information?
10. Brokers	Consider part a (ii) of definition.	Is the broker the exclusive or sole broker of the scheme?
11. Post-employment benefit plan	Consider part g) of the definition.	This will only be applicable if the scheme has employees of its own.
12. Other	Consider part a (ii) of definition.	This may include investment managers etc.
13. Trade unions		Trade unions are not necessarily related parties due to their normal dealings with the scheme (refer to paragraph 11 of IAS 24.
14. State controlled schemes		Refer SAICA Circular 4/2005 – <i>Guidance on the term ‘State Controlled Entities’ in the context of IAS 24.</i>

### What should be disclosed?

- .02 As a general guideline, depending on the circumstances, and transactions entered into by the scheme, the following disclosures should be made:

## APPENDIX VI

- *Relationships*

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, IAS 28 and IAS 31, which require a listing and description of significant investments in subsidiaries, associates and jointly controlled entities.)

- *Key management personnel remuneration*

In terms of paragraph 22 of IAS 24, schemes may split key management personnel between executive (Principal Officer and other executive management) and non-executive (Board of Trustees), and disclose remuneration for each of the following categories:

- Short-term employee benefits.
- Post-employment benefits.
- Other long-term benefits.
- Termination benefits.
- Share-based payment.

.03 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 to be disclosed per trustee.

- *Other transactions*

.04 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.

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

## APPENDIX VI

- Entities with joint control or significant influence over the entity.
  - Subsidiaries.
  - Associates.
  - Joint ventures in which the entity is a venturer.
  - Key management personnel of the entity or its parent.
  - Other related parties.
- .06 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.
- .07 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.
  - 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).

### **How much should be disclosed?**

- .08 Related party relationships and related party transactions should be disclosed when they are qualitatively (by nature) and quantitatively (by amount) material.
- .09 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 IAS24 this may be difficult to do.
- .10 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.)
- .11 IAS 24 does not allow for any relaxation for confidential or client sensitive information.

## APPENDIX VII

### ILLUSTRATIVE EXAMPLES OF RELATED PARTY DISCLOSURES

The following is an illustrative example, and the disclosures should only be made where applicable to a particular medical scheme.

#### **Background information**

##### **Related party relationships**

###### *Subsidiaries*

The consolidated financial statements include the financial statements of the subsidiaries listed in the following table:

Name	% equity interest	
	2006	2005
ABC (Pty) Ltd	100	–

There were no transactions between XYZ and ABC during the financial year (2005: Nil)

##### **Parties with significant influence over the scheme**

Employer EFG has significant influence over the Medical Scheme XYZ, as EFG participates in XYZ's financial and operating policy decisions, but does not control XYZ.

Administrator HIJ has significant influence over the 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.

Managed care organisation NOP has significant influence over the Medical Scheme XYZ, as NOP participates in XYZ's financial and operating policy decisions, but does not control XYZ. NOP provides managed care services for the scheme.

Investment management company QRS has significant influence over the Medical Scheme XYZ, as QRS participates in XYZ's financial and operating policy decisions, but does not control XYZ. QRS manages the cash investments of the scheme.

Broker Company TUV has significant influence over the Medical Scheme XYZ, as TUV participates in XYZ's financial and operating policy decisions, but does not control it. TUV provides broker services to the scheme.

##### **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 Principle 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.

##### **Transactions with related parties**

The following table provides the total amount of transactions, which have been entered into with related parties for the relevant financial year.

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### Illustrative disclosures

#### Key management personnel (Board of Trustees, Principle Officer and executive committee) and their close family members.

	2006 R	2005 R
<i>Compensation</i>		
Short-term employee benefits		
Post-employment pension and medical benefits		
Termination benefits		
Other long-term benefits		
Total compensation paid to key management personnel		

#### Contributions and claims

##### Income statement

Gross contributions received
Claims incurred
Ex-gratia payments
Healthcare provider fees paid

##### Balance sheet

Contribution debtor
Claims reported not yet paid
Savings account balances
Healthcare provider fees paid/payable

The terms and conditions of the related party transactions were as follows:

Transaction	Nature of transactions and terms and conditions thereof.
Contribution received	This constitutes the contributions paid by the related party as a member of the scheme, in their individual capacity. All contributions were at the same terms as applicable to third parties.
Claims incurred	This constitutes amounts claimed by the related parties, in their individual capacity as members of the scheme. Except for the instance noted below, all claims were paid out in terms of the rules of the scheme, as applicable to third parties.
Contribution debtor	This constitutes outstanding contributions payable. The amounts are due immediately. No provisions for doubtful debts have been raised on these amounts.
Claims reported not yet paid	These are claims that have been reported, but not yet paid due to the fact that the scheme does a payment run twice a month. All claims are settled with 30 days of being received.
Savings account balances	The amounts owing to the related parties relate to medical aid savings balances to which the parties have a right. In line with the terms applied to third parties, the balances earn interest at the prime interest rate, which accrues to the member. The amounts are all current, and would need to be payable on demand should an appropriate claim be issued, or the member exit the scheme.
Healthcare provider fees paid/payable	Fees paid to a healthcare provider (medical practitioner). Fees are paid on the same basis as applicable to third parties.

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### *Other transactions*

- The scheme obtained legal services which amounted to RXXX (2005: RXXX). The legal fees were paid on an arms length basis. The outstanding balance at year end was RXXX (2005: RXXX). The outstanding balance bears no interest and is payable within 30 days after becoming due.
- During the year, managed care: management services were rendered by key management personnel totalling RXXX (2005: 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 (2005: RXXX), and bears interest at prime less 2%. Instalments of RXXX are payable monthly.

### **Transactions with entities that have significant influence over the scheme**

	<b>2006 R</b>	<b>2005 R</b>
<b>Income statement</b>		
Grant received		
Admin refund received		
Management fees paid for reimbursement of administration and management services provided		
Administration fees		
Administration fees recovered		
Site office costs		
Rent received		
Rent paid		
Managed care fees		
Broker fees		
Investment fees payable		
<b>Balance sheet</b>		
Rent due		
Administration fees due		
Managed care fees due		
Broker fees due		
Investment fees due		

### **Terms and conditions of the rental agreement**

The rental transactions with related parties were made on terms equivalent to those that prevail in arms 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 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.

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### **Terms and conditions of the managed care agreement**

The managed care agreement is in accordance with instructions given by the Trustees of the scheme. The agreement is automatically renewed each year unless notification of termination 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 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.