CIRCULAR

Reference:	Annual returns 2023
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Date:	17 March 2025

Circular 6 of 2025: General concerns noted during the analysis of the 2023 Annual Financial Statements and Financial Annual Statutory returns

1. INTRODUCTION

1.1 Purpose

The Council for Medical Schemes (CMS) would like to express its appreciation to medical schemes, administrators and auditors for their cooperation in submitting the 2023 Annual Financial Statements (AFS) and Financial Annual Statutory Returns (FASR) within the prescribed period, as required by Circular 30 of 2024.

The purpose of this Circular is to bring to your attention common problems and issues identified during the analysis of the AFS and FASR in order to:

- Enhance the quality of data submitted in the AFS and FASR.
- Achieve standardisation and uniformity regarding proper disclosure.
- Reduce or minimise errors.
- Establish good financial reporting for the industry in line with the requirements of IFRS Accounting Standards.

1.2 Background

Medical schemes are required in terms of Section 37(4) to prepare their annual financial statements in accordance with IFRS Accounting Standards as issued by the International Accounting Standards Board. IFRS17 *Insurance contracts* became applicable for medical schemes' financial years starting 1 January 2023, with a retrospective application. The application resulted in a significant change in not only the terminology used, but also the classification and measurement of financial information in medical schemes' financial statements.

The CMS acknowledges that due to the highly technical and complex nature of the IFRS17 *Insurance contracts* application, it is anticipated that 2023 would represent the first step in the journey towards achieving an industry norm of appropriate disclosures and classifications. This Circular, therefore, seeks to not only list discrepancies in the information being furnished by medical schemes in their statutory returns, but also to highlight IFRS17 *Insurance contracts* specific matters. The users responsible for preparing the AFS and FASR, and scheme management are requested to address these matters in future submissions.

1.3 Statistics

In 2023, 71 schemes in operation. A total of 70 schemes* provided a full submission for 2023.

**Sizwe-Hosmed Medical Scheme has, however, submitted draft data. Their audit opinion and annual financial statements are pending the finalisation of a forensic investigation on claims data.*

No schemes were unlocked for correction or rejected.*

**IFRS17 Insurance contracts was adopted in the 2023 financial year, and full compliance and consistency with this standard is a journey we have embarked on together with medical schemes. CMS made the decision not to reject any medical scheme annual financial statements based on IFRS17 Insurance contracts findings.*

Furthermore, due to ongoing ICT challenges, no annual returns were unlocked. However, report-level adjustments had to be made on a few schemes.

1.4 Risk-based analysis and IFRS17 analysis theme

A risk-based analysis approach was adopted for the analysis of the AFS and FASR for 2023. Schemes were stratified based on size and demographic profile into the categories of high, medium, and low-impact schemes.

A full analysis was performed on high- and medium-impact schemes, whereas a report-level analysis was performed on low-impact schemes.

Of the 70 schemes that submitted final audited data, the classification of schemes is set out below:

Classification	Number of schemes	Beneficiaries	Beneficiaries as a % of total
High	16	8 049 540	89.5%
Medium	23	510 687	5.7%
Low	31	434 239	4.8%
	70	**8 994 466**	

During the 2023 year, the Financial Supervision identified IFRS17 *Insurance contracts* as an analysis-theme. The analysis approach adopted involved having the full Financial Supervision team review the AFS of all high-impact schemes, and 50% of the medium-impact schemes, via roundtable IFRS17 *Insurance contracts* -analysis discussions. The remaining medium impact schemes' IFRS17 *Insurance contracts* -analysis results were reviewed by a Senior Financial Analyst. A limited high-level IFRS17 *Insurance contracts* compliance overview was performed on low-impact schemes.

2. KEY AREAS OF CONCERN

The Board of Trustees Report

2.1 Operational statistics

'Relevant healthcare expenditure' is defined in the Medical Schemes Act (131 of 1998) as:
"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 any 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 any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
f) nursing or midwife, 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."

Circular 20 of 2024 engaged stakeholders on the updated operational statistics stemming from the implementation of IFRS17 Insurance contracts.

The circular proposed the inclusion of the following statistics in the Board of Trustees report:

- Relevant healthcare expenditure* ratio and Relevant healthcare expenditure incurred per average beneficiary per month (pabpm).
  *(excluding amounts attributable to members)
- Directly Attributable Insurance Service Expenses (DAE) ratio and per average beneficiary per month (pabpm).

It was noted that many schemes did not include these ratios and figures in their operational statistics notes in the Board of Trustees Report. This is partly attributable to the timing of the circular's release, which coincided with the finalisation of some schemes' AFS. Schemes are advised to include these figures in their operational statistics going forward, to allow for consistent comparisons across the industry.

Reference should also be made to the Appendix that deals with the Board of Trustees Report as per the South African Institute of Chartered Accountants (SAICA) Medical Schemes Accounting Guide for the year-end 31 December 2024 (SAICA Accounting Guide).

Annual Financial Statements (AFS)

2.2 Statement of Financial Position: Order of liquidity

Circular 41 of 2023 requested schemes to provide comments on the presentation of the Statement of Financial Position.

Paragraph 60 of International Accounting Standard (IAS) 1 Presentation of financial statements states that: "An entity shall present current and non-current assets, and current and non-current liabilities, as separate classifications in its statement of financial position in accordance with paragraphs 66–76 except when a presentation based on liquidity provides information that is reliable and more relevant. When that exception applies, an entity shall present all assets and liabilities in order of liquidity."

Paragraph 62 of IAS 1 states that: "When an entity supplies goods or services within a clearly identifiable operating cycle, separate classification of current and non-current assets and liabilities in the statement of financial position provides useful information by distinguishing the net assets that are continuously circulating as working capital from those used in the entity's long-term operations" (own emphasis).

The standard recognises that for some entities, such as financial institutions, the presentation of assets and liabilities using the order of liquidity provides information that is reliable and more relevant than a current and non-current presentation as the entity does not supply goods or services within a clearly identifiable operating cycle (see IAS 1 paragraph 63).

The CMS believes that medical schemes operate within a clearly identifiable operating cycle, which would necessitate a current, non-current presentation in the Statement of Financial Position.

Paragraph 61 of IAS 1 also indicates that regardless of which method of presentation has been adopted, the entity will still be required to disclose current and non-current assets and liabilities separately.

It was noted that 12 schemes adopted the order of liquidity to present their statement of financial position (11 of these schemes were administered by the same third-party administrator). Two of the schemes that adopted this method of classification did not classify their items from least liquid to most liquid as required by IAS 1.

The CMS will engage further with the industry on the most appropriate method of presenting the Statement of Financial Position.

2.3 Statement of Comprehensive Income – Insurance service result

Circular 12 of 2024 confirmed that the previously known net healthcare result, Section 33(2)(b) (of the Medical Schemes Act, 131 of 1998) compliance is now evaluated at the insurance service result* – level.

*excluding the "Amounts attributable to members"

The net healthcare result sub-total to the Statement of Comprehensive Income was previously the result of contributions, relevant healthcare expenditure, and non-healthcare expenditure.

The insurance service result sub-total to the Statement of Comprehensive Income was considered a close proxy of the previous net healthcare result, as it represents the result of contributions, relevant healthcare expenditure and directly attributable insurance service expenditure (which represents slightly more than 80% of the total previously known non-healthcare expenditure).

Investment income was always only taken into consideration after the net healthcare result sub-total.

It was noted that eight schemes incorrectly added investment income to the insurance service result to create a net healthcare result sub-total in its Statement of Comprehensive Income.

2.4 Statement of Cash Flows – Investment income

International Accounting Standard (IAS) 7 *Statement of Cash Flows* paragraph 33 states that there is no consensus on the classification of interest paid and interest and dividends received for entities other than financial institutions. Interest paid and interest and dividends received may be classified as operating cash flows because they enter into the determination of profit or loss. Alternatively, interest paid and interest and dividends received may be classified as financing cash flows and investing cash flows respectively, because they are costs of obtaining financial resources or returns on investments.

In Circular 52 of 2021, CMS requested that schemes report on their investment income under investing activities. This is due to Section 33(2)(b) of the Medical Schemes Act (131 of 1998) requiring each benefit option to be self-supporting in terms of financial performance. Circular 12 of 2024 clarified that compliance to Section 33(2)(b) is evaluated at the insurance service result-level (i.e. before investment income is taken into account). This sub-total is deemed to reflect the scheme's operational result.

Although Circular 18 of 2022 delayed the implementation of the above-mentioned Circular 63 of 2021, CMS is still of the opinion that investment income should be disclosed under investing activities.

It was noted that six schemes disclosed their investment income (i.e. interest received from investments other than cash and cash equivalents, and dividends received) under operating activities. The CMS will be engaging further with key industry stakeholders to determine the correct classification of investment income in the Statement of Cash Flows.

2.5 Insurance contract liabilities/assets

IFRS17 *Insurance Contracts* paragraph 55 states:

"Using the premium allocation approach, an entity shall measure the liability for remaining coverage as follows:
(a) on initial recognition, the carrying amount of the liability is:

(i) the premiums, if any, received at initial recognition;

(ii) minus any insurance acquisition cash flows at that date, unless the entity chooses to recognise the payments as an expense applying paragraph 59(a); and

(iii) plus or minus any amount arising from the derecognition at that date of:

1. any asset for insurance acquisition cash flows applying paragraph 28C; and
2. any other asset or liability previously recognised for cash flows related to the group of contracts as specified in paragraph B66A.

(b) at the end of each subsequent reporting period, the carrying amount of the liability is the carrying amount at the start of the reporting period:

(i) plus the premiums received in the period;

(ii) minus insurance acquisition cash flows; unless the entity chooses to recognise the payments as an expense applying paragraph 59(a);

(iii) plus any amounts relating to the amortisation of insurance acquisition cash flows recognised as an expense in the reporting period; unless the entity chooses to recognise insurance acquisition cash flows as an expense applying paragraph 59(a);

(iv) plus any adjustment to a financing component, applying paragraph 56;

(v) minus the amount recognised as insurance revenue for services provided in that period (see paragraph B126);

(vi) minus any investment component paid or transferred to the liability for incurred claims."

2.5.1 There is a difference in the technical interpretation of whether specific items within the Liability for Remaining Coverage (LFRC) may be transferred to the Liability for Incurred Claims (LIC) or not. Further engagements with the SAICA Medical Schemes Project Group (MSPG) are necessary to ensure the appropriateness of the transfer of the following items in terms of an accounting policy choice:

- Contribution receivables.
- Personal Medical Savings Accounts (PMSA's) contributions.

2.5.2 The following was noted regarding schemes' reconciliation of the LIC:

- Two schemes did not include the risk adjustment for non-financial risk in their LIC as required by IFRS17 paragraph 100(c)(ii).
- It was noted that one scheme incorrectly disclosed a provision for impairment for insurance receivables that are not expected to be recovered. The present value of future cash flows included in the LIC have already been adjusted for recoverability within the fulfilment cash flows as indicated in IFRS17 paragraph 59(b). IFRS17 paragraph 33(b) further indicates that these cash flows must be probability weighted and take into account the amount, timing and uncertainty of those future cash flows.

2.5.3 Other items:

- Cash Flows disclosed in these reconciliations could not be fully reconciled back to the scheme's Statement of Cash Flows or the notes thereto. Kindly refer to the 'Additional disclosure considerations' below.
- Schemes did not provide a breakdown of what is included in the final asset/liability i.e. outstanding contributions, claims reported not yet paid etc. This would also assist members understanding of these amounts and can also be reconcilable to the various parts within the Annual Return. Kindly refer to the 'Additional disclosure considerations' below.

2.6 Investments at fair value through other comprehensive income (FVOCI) reserve

Many schemes that had investments measured at FVOCI did not provide a reconciliation on the movements within this reserve in their AFS. Whilst this reserve is now included in the amounts attributable to members-liability due to medical

schemes being considered mutual entities, a reconciliation within the amounts attributable to members liability disclosure note must still include a reconciliation of the movements in this reserve.

2.7 Amounts attributable to members:

Medical schemes are considered to be mutual entities for the purposes of applying IFRS17 *Insurance contracts*. As a result, the amounts attributable to members (previously accumulated funds) are disclosed as a liability owing to its members. CMS would typically expect this liability to be disclosed under non-current liabilities due to the long-term nature of this liability. A portion of this liability would be disclosed under current liabilities, where the scheme expects a deficit for the following year (i.e. it would be realised within the next 12 months).

- Four schemes disclosed a separate liability (amounts attributable to members) under current liabilities, but did not provide information that explains what this liability relates to (i.e. deficit budgeted for the following year).
- Seven schemes included the full liability to members under current liabilities (stratification per auditor was noted). This disclosure originated from initial technical considerations in the IFRS17 journey that considered the liability being payable on demand. As this liability is not to be realised within the next year (unless there is a going concern issue), it must be disclosed under non-current liabilities.

2.8 Insurance Revenue: Recoverability of contribution receipts

Four schemes disclosed impairment losses on contribution receivables in the Statement of Comprehensive Income. Per IFRS17 paragraph B126, for schemes that apply the premium allocation approach, insurance revenue for the period is the amount of expected premium receipts (excluding any investment component) allocated to the period. The scheme should therefore reduce the insurance revenue with the contributions that are not expected to be received and appropriately disclose this in the insurance revenue note in the AFS.

2.9 Accredited managed care fees

It was noted that three schemes did not provide the necessary disclosure of the schemes' accredited managed care fees per service as required by Circular 56 of 2015. These services are required to be included as part of claims, but separate disclosure of the accredited services provided is necessary.

2.10 Accredited administration fees paid to the administrator

It was noted that two schemes did not disclose the necessary breakdown of the schemes' accredited administration fees per service as required by Circular 77 of 2019.

2.11 Directly attributable and Not directly attributable insurance expenses

Cash flows within the boundary of an insurance contract are those that relate directly to the fulfilment of the contract and include those over which the entity has discretion.

IFRS 17 states the following regarding these cash flows:
The cash flows within the boundary of a contract include:

i) an allocation of fixed and variable overheads (such as the costs of accounting, human resources, information technology and support, building depreciation, rent, and maintenance and utilities) directly attributable to fulfilling insurance contracts.

Such overheads are allocated to groups of contracts using methods that are systematic and rational and are consistently applied to all costs that have similar characteristics (IFRS 17.B65).

IFRS 17.B66 states that the following cash flows shall not be included in the fulfilment cash flows: (d) cash flows relating to costs that cannot be directly attributed to the portfolio of insurance contracts that contain the contract, such as some product development and training costs. Such costs are recognised in profit or loss when incurred.

Circular 29 of 2023 was issued requesting comments from the industry on the proposed split of its operational expenditure between directly attributable and non-directly attributable expenditure. The results of the feedback from the industry were however not conclusive. CMS will be engaging further with the industry based on the findings of the 2023 annual financial statements analysis.

It was observed that the allocation per the definition above was not consistently applied by schemes.

a) In four instances, the split between direct and not directly attributable expenditure was not clear from the notes to the schemes' AFS.
b) It was also noted that one scheme did not include all the accredited administration fees as directly attributable expenditure in the AFS.

2.12 Benefit options results

Circular 12 of 2024 confirmed that schemes must exclude the amounts attributable to members from its benefit options results (i.e. the amounts attributable to members must not be included in the insurance service expenditure line item and therefore should not be allocated to the benefit options).

It was noted that 16 schemes did not exclude the amounts attributable to members line item from its benefit options results note. It is not deemed sufficient to disclose only the insurance service result and net result without this figure. The exclusion of this item in all the individual lines within the benefit options' financial performance disclosure note would allow members to compute relevant healthcare expenditure ratios per benefit option and to determine which benefits options are not self-supporting in terms of Section 33(2) of the Act.

CMS is cognisance of the fact that reconciling line-item disclosure would be necessary in order to allow for the benefit option result disclosure note to agree to the results as disclosed in the Statement of Comprehensive Income. The reconciling items should however be presented in such a way that the medical scheme member can at a bird's eye view observe the benefit option performance excluding the amounts attributable to members-figure.

2.13 IFRS 12 *Disclosure of Interests in Other Entities*

Five schemes did not consider IFRS12 disclosures in their annual financial statements. Schemes are urged to include the disclosure required, ensuring that an accounting policy and detailed disclosure note has been included.

2.14 Additional disclosure considerations IAS1 paragraph 17(c) requires entities to provide additional disclosures when compliance with the specific requirements in IFRS is insufficient to enable users to understand the impact of particular transactions, other events and conditions on the entity's financial position and financial performance.

The following additional disclosures by medical schemes were noted during our analysis of schemes' AFS, and were considered to meet the requirements imposed by paragraph 17(c):

a) Reinsurance contracts:
   17 medical schemes disclosed detailed information on each reinsurance arrangement contracted, and the value provided by these contracts (by virtue of the disclosure of the capitation fees paid and the estimated recoveries per individual contract) in their AFS.
b) Insurance contract liabilities:
   a. Liability for Remaining Coverage (LFRC) and Liability for Incurred Claims (LIC): a reconciliation between the amounts disclosed as the cash flows for the year and the amounts presented in the Statement of Cash Flows were provided by 12 schemes.
   b. Liability for Remaining Coverage (LFRC) and Liability for Incurred Claims (LIC): detail was provided on the balances that represented the liability (for example, claims reported not yet paid, outstanding contributions, etc.) by 21 schemes.
c) Amounts attributable to members:

A reconciliation between the opening and closing balances were provided by 23 schemes.

d) Liquidity risk analysis:
18 schemes provided information on the matching of its assets with its liabilities

Medical schemes are requested to add these disclosures to their AFS going forward.

Financial risk management report

2.15 Credit risk ratings

16 schemes provided inadequate disclosure of credit risk ratings per institution as required by IFRS7 paragraph 35M: "an entity shall disclose, by credit risk rating grades, the gross carrying amount of financial assets". Schemes are urged to ensure that the appropriate disclosure in terms of IFRS7 is included in their annual financial statements.

Financial Annual Statutory Returns (FASR)

2.16 Part 1.4 - Report of the Board of Trustees (BoT Report)

Five schemes did not respond accurately to the following questions posed in part 1.4:

- Question 3: Has any company/institution/person to your knowledge received or dealt with the contributions of the scheme otherwise than in terms of Section 26(6)?
- Question 18(a): Do the notes to the financial statements fully include contingent liabilities?

Schemes and audit committees are urged to pay specific attention to this area since it represents the governance section to the annual statutory return.

Schemes should ensure that each question is answered correctly and that the necessary details are provided. It should also be noted that the scheme, in answering the questions, should provide full details and not refer to the financial statements.

Non-compliance should be fully disclosed in this part. Corrective courses of action implemented should be included in the answers provided, this would include any exemptions granted. It is *not* deemed sufficient to refer to the notes to the AFS.

2.17 Insurance contract payables and receivables

It was noted that three schemes did not differentiate appropriately between the insurance and non-insurance payables and receivables in Parts 4.3(a) and (b), and 4.8(a) and (b). Schemes are urged to split the payables and receivables appropriately and that these agree to the disclosure in the annual financial statements.

2.18 Part 4.16.1 Administration expenditure split

It was noted that schemes' disclosure of directly attributable and not directly attributable administration expenditure was not consistent with that of the schemes' AFS. Schemes are urged to split their directly attributable and not directly attributable administration expenditure correctly in this part and ensure that it agrees with the AFS.

2.19 Part 6: Onerous contracts

Onerous contracts line 6.1.10.1 was created to allow schemes to capture their pricing deficit for the following year. None of the schemes that disclosed a separate liability (amounts attributable to members) under current liabilities, made use of this line to capture the next year's pricing deficit. Schemes are urged to disclose their pricing deficits separately in line 6.1.10.1 in future submissions.

2.20 Part 9(a) – Investments

A number of medical schemes completed Part 9(a) of the return incorrectly. Issues identified include:

- General misclassification within 16 schemes.
- Drop-downs provided were not utilised by 12 schemes;

- Full disclosure of entity names not provided (only instrument codes were provided) by five schemes;
- Instrument codes not provided (only entity names were provided) by five schemes;
- Certain funds not being broken down into the underlying assets as per Explanatory Note 8 of Annexure B by one scheme; and
- Insufficient documentation supporting reclassification of investments to other categories as required in Circulars 12 and 19 of 2023. This was noted for five medical schemes.

In future, please ensure that the investments are classified correctly to assist with compliance monitoring. The Guidelines on the categorisation of assets in terms of Regulation 30 of the Act, read in conjunction with Annexure B to the Regulations, are published on our website for further guidance in this regard.

2.21 Reporting of non-compliance matters:

In Circular 11 of 2006, Circular 30 of 2007 and Circular 14 of 2008, the CMS has directed schemes that all non-compliance matters should be disclosed in both the BoT Report and the scheme's AFS.

The following non-compliance matters were not reported:

- Six schemes did not disclose non-compliance with Regulation 30, read in conjunction with Annexure B.
- Three schemes did not disclose Section 33(2) non-compliance for benefit options that are not self-supporting.

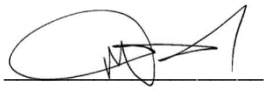
Schemes are required to disclose the following information relating to all non-compliance issues (regardless of whether the scheme has addressed the non-compliance or not):

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

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

The CMS is looking forward to improved AFS and FASR submissions in future and highly appreciates your cooperation.

Yours sincerely,



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