



**COUNCIL FOR MEDICAL SCHEMES**

**Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option(s) as per Section 33 of the Medical Schemes Act 131 of 1998, as amended.**

**September 2009**

# **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

<b>1.</b>	<b>Introduction .....</b>	<b>3</b>
<b>2.</b>	<b>Business plan format.....</b>	<b>3</b>
	<b>2.1 Executive summary .....</b>	<b>3</b>
	2.1.1Objective .....	3
	<b>2.2 Medical scheme summary .....</b>	<b>4</b>
	2.2.1Background information in respect of the medical scheme .....	4
	<b>2.3 Strategy and implementation.....</b>	<b>4</b>
	2.3.1SWOT analysis .....	4
	<b>2.4 Benefit options.....</b>	<b>6</b>
	2.4.1Benefit design .....	6
	2.4.2Analysis of benefit structures of the existing options as well as the new/restructured options.....	7
	<b>2.5 Market analysis.....</b>	<b>8</b>
	2.5.1Membership/Target market strategy .....	8
	2.5.2Market comparison .....	9
	<b>2.6 Pricing strategy.....</b>	<b>10</b>
	2.6.1Contributions.....	10
	2.6.2Affordability of contributions.....	12
	2.6.3Benefits .....	13
	2.6.4Non-health expenditure .....	14
	2.6.5Reserve building.....	15
	<b>2.7 Risk management .....</b>	<b>15</b>
	<b>2.8 Financial plan.....</b>	<b>16</b>
	<b>2.9 Independent review .....</b>	<b>16</b>
<b>3.</b>	<b>Annexures to the business plan.....</b>	<b>17</b>
	<b>3.1. Annexure A – specimen monthly statement of comprehensive income (consolidated &amp; per option).....</b>	<b>17</b>
	<b>3.2. Annexure B – specimen year to date statement of comprehensive Income .....</b>	<b>19</b>

# **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

## **1. Introduction**

Section 33 of the Medical Schemes Act 131 of 1998 ("Act"), as amended states:

*"A medical scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.*

*The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option –*

- a) includes the prescribed minimum benefits;*
- b) shall be self-supporting in terms of membership and financial performance;*
- c) is financially sound; and*
- d) will not jeopardise the financial soundness of any existing benefit option within the medical scheme."*

The purpose of this document is to guide and assist medical schemes in submitting the information in the form of a business plan that will expedite the whole process of consideration of an application for approval of (a) new benefit option(s). It should be noted that this document should also be used where schemes are planning to materially restructure any of its existing registered option(s).

An option is deemed to be a restructured option when the structure of an existing option changes, by addition or deletion of a group/s of benefits which could include a self-funding gap, threshold and above-threshold benefits.

It is important to ensure that at all times the proposed new/restructured option(s) are in the best interest of the members of the medical scheme concerned.

## **2. Business Plan Format**

### **2.1 Executive Summary**

#### **2.1.1 Objective**

The medical scheme must submit sufficient information relating to its intention to register a new benefit option or to restructure any of its existing registered option(s).

This must include, amongst other things, the following minimum information:

- A brief description of the existing benefit options.
- A brief description of the new/restructured option(s); indicating what the preferred outcome (main objective/purpose) is of the new/restructured option(s) (i.e. the gap it intended filling in the scheme's current options structure).
- A summary of why the scheme needs the new/restructured option(s).
- A comparison of the new/restructured option(s) with the current option(s); the scheme should also indicate why the new/restructured option(s) will be attractive to the market/members (i.e. market comparison).
- The scheme should conclude whether the new/restructured option(s) will comply with the provisions of section 33 of the Medical Schemes Act.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

In introducing a new benefit option, there may be changes within existing options that may alter the current solvency and even liquidity state of the scheme. Such factors or changes will need to be taken into account from design, marketing and implementation of the benefit option.

The scheme will therefore have to outline where possible, all those factors including those mentioned above and the overall effect on the reserves of the scheme. Further, the resultant changes may negatively impact on the existing options. In that case, a synopsis of how the scheme will address the issue in evaluating the entire business plan/ application for registration of such benefit option(s) must be submitted.

### **2.2 Medical Scheme Summary**

#### **2.2.1 Background information in respect of the medical scheme**

The scheme should provide a brief history of its operations, which should include at least the following information:

- 1) Name and registration date of the scheme.
- 2) The number and names of benefit options currently offered by the scheme.
- 3) A brief description of the current options (objective of each individual option) as well as the target market for every option (e.g. low cost).
- 4) Summary of the membership profile per option for example:
  - Number of members.
  - Number of beneficiaries.
  - Average age of beneficiaries.
  - Pensioner ratio (65+ years).
  - Number of chronic patients.
  - Membership mix or different income bands
  - Family size.
- 5) Developments within the scheme over the past few years (i.e. previous amalgamations).
- 6) Name of participating employer groups (only major groups for open schemes).
- 7) Name of administrator (only for third party administered schemes), including organogram of the administrator and its related parties.
- 8) Name of managed care provider(s) and services delivered, including an organogram of the managed care provider(s) and its related parties.
- 9) Names and relationships with all related parties of the scheme, including an organogram where applicable.
- 10) A full list of all the guarantees that the scheme has in place.

### **2.3 Strategy and implementation**

#### **2.3.1 SWOT analysis**

##### **2.3.1.1 Strength and opportunities**

The scheme must give a brief overview of factors considered strengths and those being opportunities, as well as the reasons why the scheme considers these factors as such, and in what way such factors will assist the scheme to perform satisfactorily.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

Possible strength factors could include but are not limited to the following:

- A competitive product offering, including the reasons for the scheme being competitive.
- Effective risk management (e.g. capitation arrangements with managed care networks).
- Quick hassle free claims turn around as a result of type of system utilised; thus pleased members.
- Reduced administration expenditure per beneficiary, compared to the industry average.
- Improved age profile as a result of new options or better marketing; thus lower claims ratio compared to industry average.
- Stable risk pool due to younger, healthier members.
- Good investment strategy.

Possible opportunity factors could include but are not limited to the following:

- Member communication.
- Good risk profile member growth.
- Compulsory membership.
- Advertising / branding.

The above factors merely serve as an example of what survival of a medical scheme. Each scheme's circumstances will be different and schemes should not feel obliged to concentrate on or limit their analysis to only the factors mentioned above.

### **2.3.1.2 Weaknesses and threats**

Similarly, an overview of factors considered being weaknesses and threats to the scheme. The scheme should also indicate how it plans to deal with those threats and weaknesses (i.e. risk mitigation plan).

Factors that could be a threat or even a weakness could include but are not limited the following:

- Existence of the Government Employees Medical Scheme (GEMS) and the resulting loss of membership.
- Poor risk profile due to higher age profile of members.
- Higher than average claims pattern due to higher pensioner ratio.
- Dissatisfied members due to late claims processing and payments.
- Failure to attract sufficient members to increase the size of the risk pool.
- Spiralling costs of medication and private hospital costs; thus threatening the solvency and viability of the scheme.
- Potential/looming retrenchment in the industry where most of the members of the scheme operate (economic factors).
- Statutory regulations/ amendments (i.e. PMBs being paid at cost).
- Threat of HIV/Aids and other chronic diseases.
- Fraud and corruption.
- Poor returns on investment.
- Quality of management information.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

The above factors merely serve as an example of what could affect the survival of a medical scheme. Each scheme's circumstances will be different and schemes should not feel obliged to concentrate on or limit their analysis to only the factors mentioned above.

### **2.4 Benefit options**

#### **2.4.1 Benefit design**

The scheme should provide a detailed description of the option(s) as well as the main objective/purpose for the registration of the new/restructured option(s).

A summary of the membership demographic profile of the option should be provided: i.e. average age, family size, pensioner ratio (defined as 65 years and older), number of chronic patients etc.

The scheme should also include the rules of the new/restructured option(s).

The following table is an example of how scheme options can be summarized:

<b>Name</b>	<b>Option A</b>	<b>Option B</b>	<b><i>New Option C</i></b>	<b><i>Restructured Option D</i></b>
Type	Traditional – Fee for service	New generation – negotiated fee for service	Capitated	Capitated - low cost
Income bands (per rules or per target group/market)	< R 1000 R 1 000 – R3 000 R3 001 – R5 000 > R5 000	No income bands	< R4 000 > R4 000	< R2 500 > R2 500
Average Contributions - per member per month	R3 000 per member per month	R2 200 per member per month	R1 100 per member per month	R500 per member per month
- per beneficiary per month	R2 000 per beneficiary per month	R1 100 per beneficiary per month	R650 per beneficiary per month	R250 per beneficiary per month
Average family size	2.7	2.5	2.8	2.8
In-hospital benefits (overall limits & Rate) - PMB - Non PMB	Unlimited Unlimited	Unlimited Unlimited	Unlimited R500 000 per family per annum	Unlimited R200 000 per family per annum
Out-hospital benefits (overall limits & Rate) - PMB - Non PMB	Unlimited Limited to 200% of NRPL	Unlimited Limited to NRPL	Unlimited Unlimited capitated	Unlimited None
Personal Medical Savings Accounts	N/A	Compulsory 25.0%	Compulsory 10.0%	N/A

## Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option

Name	Option A	Option B	<i>New Option C</i>	<i>Restructured Option D</i>
Average age	27.4	38.6	31.9	29.6
Pensioner ratio	2.9%	16.4%	6.8%	3.3%
No. of chronic beneficiaries	35.1%	23.2%	7.6%	3.4%

For restructured options, the scheme should illustrate exactly how the options will be restructured and the cost savings per discipline that the scheme will have as a result of the restructuring.

The following table is an example of an illustration of how a scheme proposes to restructure its options:

Year 1	Year 2
Option A	Option A
Option B – Network A	Option B - Primecure & Carecross
Option C – Network B	
Option D – Network C	
Option E – Network D	Option C – Medicross
Option F – Network E	Option D – BIPA & Faranani
Option G	
	Option E

The table below illustrates the cost saving for the scheme, by introducing co-payments to members; hence shifting a portion of the benefit expenditure to the members:

Benefit	Co-payment introduced	Average visits/consultations per month	Total co-payments per month
Co-payment for first night in hospital	R250	150	R37 500
Co-payment for day admissions in hospital	R100	12	R1 200
Co-payment for specialists consultation	R30	4 500	R135 000
<b>Total decrease in claims per month</b>			<b>R173 700</b>
Total claims per month			R6 948 000
Percentage cost saving			2.5%

### 2.4.2 Analysis of benefit structures of the existing options as well as the new/restructured options

The scheme should perform a detailed comparison between the benefit design of the existing options and the new/restructured option(s).

Existing Option A	Existing Option B	New Option C	Restructured Option D
<ul style="list-style-type: none"> <li>No overall hospital limit</li> <li>200% of NRPL</li> <li>sub limits applicable</li> </ul>	<ul style="list-style-type: none"> <li>No overall hospital limit</li> <li>100% of NRPL</li> <li>sub limits</li> </ul>	<ul style="list-style-type: none"> <li>R500 000 overall hospital limit per family</li> <li>100% NRPL</li> </ul>	<ul style="list-style-type: none"> <li>R200 000 overall hospital limit per family</li> <li>100% NRPL within a</li> </ul>

**Guideline for the preparation of a business plan pursuant to an application  
for the registration of a new/restructured benefit option**

Existing Option A	Existing Option B	New Option C	Restructured Option D
	applicable	within a network hospitals <ul style="list-style-type: none"> <li>R500 deductible is payable for certain procedures</li> </ul>	network hospitals <ul style="list-style-type: none"> <li>sub limits applicable</li> </ul>
No Threshold	Threshold: M = R5 300 AD = R3 800 CD = R1 700	No Threshold	No Threshold
General practitioners - Unlimited	General practitioners – Limited to 20 visits per family	General practitioners – limited to network of doctors	General practitioners – R600 per beneficiary
Specialist services - Unlimited	Specialist services – Limit of R50 000 per family	Specialist services - limited to network of doctors	Specialist services – No benefit
Surgical procedures – limit of R20 000 per family	Surgical procedures – No benefit	Surgical procedures – limit of 1 procedure per dependant at network hospital	Surgical procedures – No benefit

M = Member

AD = Adult Dependent

CD = Child Dependent

## **2.5 Market analysis**

### **2.5.1 Membership/Target market strategy**

The scheme will have to project the proposed membership per new/restructured option(s). The scheme should also indicate who is targeted with the new/restructured option(s).

The scheme should submit at least the following information per option (for current and new/restructured option(s)):

- A detailed marketing strategy.
- Forecast in terms of membership growth including reasonability testing.
- Detailed demographic profile of the current and projected beneficiaries (i.e. average age and pensioner ratio (65+ years)).
- Geographical area of the current and projected members and beneficiaries, if applicable.
- Current and projected average family size for the new/restructured options, compared to the existing options.
- If the contribution tables differentiate between income bands, the scheme should indicate the number of members per income band. If the scheme's contribution tables do not



## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

provide for income bands, an indication of the salary income bands of the proposed target market.

- Illustrate the impact of the risk profile of the new members on the existing membership and the scheme's solvency level.
- Probability of movement of members between options, and the impact thereof on the self-sustainability of the options (i.e. buy ups and buy downs).
- The assumed movement of members between options.
- Methods to ensure that actual experience reflects the expected movements assumed in the point above, as well as the mitigating options identified by the scheme to address the adverse movement of members.
- Customer needs analysis.
- The scheme should provide any letter(s) of intent by prospective employers, if applicable.
- The scheme's communication strategy (i.e. road shows, pamphlets, advertising, etc)

It should be noted that the recommended minimum number of members per option is 2 500 principal members.

The table below depicts the scheme's membership mix after the new option(s) has been introduced/restructured.

<b>Membership mix</b>	<b>Average members</b>	<b>Ratio</b>	<b>Average beneficiaries</b>	<b>Ratio</b>
Option A < R 1000 R 1 000 – R3 000 R3 001 – R5 000 > R5 000				
Option B (no income bands)				
Option C < R4 000 > R4 000				
Option D <R2 500 >R2 500				
<b>Total scheme</b>				

### **2.5.2 Market comparison**

The scheme should also provide an analysis of the option's primary competitors. The following information should at least be included in the submission:

- Comparable benefits i.e. similar offerings by competitors.
- Range of options (i.e. number of options).
- Differentiation in respect of level of benefits:
  - Broad categories (in-hospital/chronic/out of hospital).
  - Overall limit range.
  - Limit on day-to-day benefits.
  - Limit on non-PMB chronic benefits.
  - Network/Capitated.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

- Differentiation in respect of structure of benefits:
  - Traditional.
  - New generation.
  - Network.
  - Contributions.
- Comparison of contributions

The following table serves merely as an example and should be adjusted relevant for the new/restructured option(s), compared to the scheme's peers' options:

<b>Name</b>	<b>New/restructured Option A</b>	<b>Medical scheme Peer A Option 1</b>	<b>Medical scheme Peer B Option 5</b>
Type	Traditional – Fee for service	New generation – negotiated fee for service	Traditional – Fee for service
Income bands	< R1 000 R1 001 – R3 000 R3 001 – R5 000 > R5 000	No income bands	< R4 000 > R4 000
Average Contributions	<ul style="list-style-type: none"> <li>• R3 000 per member per month</li> <li>• R1 000 per beneficiary per month</li> </ul>	<ul style="list-style-type: none"> <li>• R2 500 per member per month</li> <li>• R2 200 per beneficiary per month</li> </ul>	<ul style="list-style-type: none"> <li>• R3 100 per member per month</li> <li>• R1 300 per beneficiary per month</li> </ul>
In-hospital benefits (overall limits & Rate)	Unlimited	Unlimited	R2 000 000 per family per annum
Out-hospital benefits (overall limits & Rate)	Unlimited	Limited to NRPL	Limited to 200% of NRPL
Chronic conditions	Formulary PMB	PMB	Formulary PMB plus 8 other chronic conditions limited to R10 000 per family.
Personal Medical Savings Accounts	N/A	15% of total contributions	20% of total contributions

## **2.6 Pricing strategy**

### **2.6.1 Contributions**

The scheme should provide detailed contribution tables per option as well as the underlying assumptions for the pricing of the contributions.

The following table depicts the contribution structure of income based option(s):

## Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option

### Option A:

Income bands	Member	Adult dependant	Child dependant
R0 – R1 000			
R0 – R1 000 (savings)			
R1 001 – R3 000			
R1 001 – R3 000 (savings)			
R3 001 – R5 000			
R3 001 – R5 000 (savings)			
R5 001 plus			
R5 001 plus (savings)			

The following table depicts the contribution table for an option, which is not income based:

### Option B:

	Member	Adult dependant	Child dependant
Option 2			
Option 2 (savings)			

It is very important to note the basis/underlying assumptions for arriving at the monthly contribution rate charged. The breakdown of the monthly contribution should be on the basis of per member / per beneficiary per month.

The following tables depict the minimum information to be disclosed:

Description	Option A				Option B			
	pmpm	% of GCI	pbpm	% of GCI	pmpm	% of GCI	pbpm	% of GCI
Risk portion – Health related								
Risk portion – Non-health related								
Savings portion								
Contribution to Reserves/Investment income								
<b>Total proposed premium per month</b>								

pmpm=per member per month  
pbpm=per beneficiary per month  
GCI =Gross Contribution Income

The assumptions to the above figures and calculations should also be provided per benefit option; the following are a few examples of assumptions to be documented:

- Description of data used.
- Price inflation.
- Age adjustments.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

- Benefit changes.
- Utilisation adjustments.
- Non-health expenditure.
- Investment return.
- Reserve loading.
- Demographic profile of members:
  - Average age.
  - Pensioner ratio (65+ years).
  - Average family size per option.
  - Chronic profile.
  - Income profile.
- Buy-downs/ups.
- Subsidy (if any) assumptions and the impact on the proposed contributions table.

The proposed new contribution tables should also be compared to the contribution tables of the existing options. The scheme should indicate the probability of any risk of buy-downs by members to the lower cost options. The scheme should further indicate how this movement of members will impact on the overall performance of the scheme.

For restructured options the scheme should compare the new proposed contribution table with the previous contribution table (before restructuring). Detailed reasons should be listed for the difference in the contribution tables.

This merely serves as a guide and is not in anyway exhaustive of the assumptions that may be used. A detailed explanation of both the assumptions and the basis or impact these will have on the financial position need to be submitted.

### **2.6.2 Affordability of contributions**

Based on the fact that an option would be targeted at a specific income group, the scheme should further comment on the affordability of the new option in relation to the household income (e.g. 22.5% of a member's household income (monthly) will go towards medical aid contributions). The scheme must also give an indication of how many members receive employer subsidies.

	<b>Option A</b>		<b>Option B</b>	
		<b>% of salary</b>		<b>% of salary</b>
Contribution per member per month	<b>R400</b>		<b>R800</b>	
Salary bands	R1 000	40.0%	R 8 000	10.0%
	R3 000	13.3%	R10 000	8.0%
	R5 000 +	8.0%	R12 000 +	6.6%
Contribution per beneficiary per month	<b>R300</b>		<b>R600</b>	
Salary bands	R1 000	30.0%	R 8 000	7.5%
	R3 000	10.0%	R10 000	6.0%
	R5 000 +	6.0%	R12 000 +	5.0%

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

### **2.6.3 Benefits**

The projected claims costs for each option should be listed in the business plan on the basis of per member/beneficiary per month. Detailed calculations and assumptions on which the benefits are based should be provided.

The following is an example of the minimum information to be disclosed:

<b>Pricing of contribution</b>	<b>Option 1</b>				<b>Option 2</b>			
<b>Year Start</b>	<b>pmpm</b>	<b>% of GCI</b>	<b>pbpm</b>	<b>% of GCI</b>	<b>pmpm</b>	<b>% of GCI</b>	<b>pbpm</b>	<b>% of GCI</b>
In-hospital benefits								
Chronic benefits								
MRI & CT scans								
Oncology								
Internal Prosthesis								
Dialysis								
Optical								
Dentistry								
Radiology								
Pathology								
GP's & Specialists								
ATB								
Threshold benefits								
Capitated benefits								
- PMB								
- Non-PMB								
<b>Total benefit</b>								

pmpm=per member per month

pbpm=per beneficiary per month

GCI = Gross Contribution Income

In addition, the scheme should also include a detailed list of benefit reduction/enhancements projected per discipline. This analysis should be done on a per member per month/per beneficiary per month basis and as a percentage of previous benefits offered.

Where applicable, the scheme should also indicate the level of co-payments by members. The co-payments on the new/restructured option should be compared with the co-payment of the existing options/previous option before restructuring.

Where a scheme enters into any capitation arrangements, the scheme should submit a copy of the proposed contract, as well as a detailed list of all services covered in the proposed agreement. The capitation fee paid should also be justified.

For restructured options a detailed comparison needs to be done between the new restructured option and the previous option before restructuring, for example:

**Guideline for the preparation of a business plan pursuant to an application  
for the registration of a new/restructured benefit option**

<b>Benefit</b>	<b>New restructured option</b>	<b>Previous option before restructuring</b>
Day to day/ MSA / Above threshold benefits	None	<ul style="list-style-type: none"> <li>Day to day benefits</li> <li>Savings (MSA)</li> <li>Above Threshold Benefits (ATB)</li> </ul>
Chronic	<ul style="list-style-type: none"> <li>Non PMB limits: Per beneficiary = R4 800 Per family = R9 600</li> <li>Levy = R25 per script</li> <li>Non DSP - 20% co-payment</li> </ul>	<ul style="list-style-type: none"> <li>Non PMB limits: M0 = R4 300 M1+ = R8 600</li> <li>Co-payment = 10% (DSP)</li> <li>Non DSP – Paid from Acute medication</li> </ul>
MRI and CT scans	Limit = 2 scans	No limit
Acute Medication	From MSA	<ul style="list-style-type: none"> <li>90% of scheme rate from day to day benefits thereafter from MSA</li> <li>Limited to Day to day benefits/MSA</li> </ul>
Dentistry	<ul style="list-style-type: none"> <li>90% of scheme tariff</li> <li>Limits: M0 = R1 000 M1 = R2 000 M2 = R2 500 M3 = R3 000</li> <li>Orthodontic limit = R1 000 per family</li> </ul>	<ul style="list-style-type: none"> <li>Hospital – first R1 000 from Day to day benefits/MSA, thereafter from MMB</li> <li>Out-of-hospital – from day to day benefits/MSA</li> <li>Overall limit = R12 500 per beneficiary</li> </ul>
External Prosthesis	<ul style="list-style-type: none"> <li>80% of cost</li> <li>Limit = R5 000 for hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>day to day benefits/MSA</li> <li>Limit = R12 000 per family</li> <li>Limit = R8 000 for hearing aids</li> </ul>

## 2.6.4 Non-health expenditure

The scheme should perform a detailed analysis of the non-health expenditure, expressed as a percentage of gross contribution per member per month / per beneficiary per month.

<b>Total non-health costs</b>	<b>Option 1</b>				<b>Option 2</b>			
	<b>pmpm</b>	<b>% of GCI</b>	<b>pbpm</b>	<b>% of GCI</b>	<b>pmpm</b>	<b>% of GCI</b>	<b>pbpm</b>	<b>% of GCI</b>
Administration expenditure								
-Administration fees								
-Other administration expenditure								
Managed care: management services								
Broker fees								
Commercial reinsurance								
Impairment losses								
<b>Total</b>								

pmpm – per member per month

pbpm – per beneficiary per month

GCI – Gross Contribution Income

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

Details of the other administration costs should also be specified. If administration costs exceed 10% of contributions, an explanation should be provided.

The scheme should also provide a list of managed care providers it has contracts with, a description of the services to be provided together with copies of the contracts.

### **2.6.5 Reserve building**

The scheme should indicate the extent to which the new/restructured option(s) will contribute to reserve building. Details of the scheme's reserving policy should also be provided.

The submission should also include sensitivity analyses illustrating the impact on the scheme's reserves. The following are examples of such sensitivity analyses:

- The impact of different utilisation patterns on the projected solvency levels.
- The impact of different risk profiles of members on the projected solvency levels.
- Increase in the proportion of lower income members joining the option.
- The impact of different membership targets on the projected solvency levels.
- The impact of buy-downs on the projected solvency.

The above-mentioned analysis could be summarized as follow:

<b>Scenario</b>	<b>% change in insured contributions required to sustain reserves</b>	<b>% change in the end-period reserves if contributions are unchanged</b>
A		
B		
C		
D		

A break-even analysis illustrating the minimum required income to cover all claims and non-health costs, and all assumptions used for the year on year increases should be included.

### **2.6 Risk management**

Risk management is a key component of scheme management. A clear policy on how the scheme plans to minimise its exposure to risk can take countless forms that could include any of the following:

- Risk transfer arrangements with managed health care providers where an element of risk is transferred to the risk provider or is shared between the scheme and the provider.
- Capping of claims payable to contracted providers in return for unlimited services to members, thus reducing exposure to high inherent claims risk.
- For schemes that do not have large membership, reinsurance can afford them an effective vehicle to manage and contain risk. It should be noted that it is the responsibility of the Board of Trustees to consider the need for such reinsurance and to comply with Section 20(3) of the Act, in this regard.

## **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

The scheme should provide full details on risk management tools currently in place as well as those risk management tools to be implemented and an evaluation of the effectiveness thereof. The scheme should also provide copies of all agreements. Any proposed risk sharing arrangements should be supported by appropriate reasons for implementation thereof. (i.e. needs analysis)

### **2.7 Financial plan**

The scheme should provide a historical summary regarding the financial soundness of its options.

Furthermore, the scheme should provide financial projections based on the introduction of the new/restructured benefit option(s). The projections should cover a period of at least two full calendar years.

Projections shall comprise of at least the following information (this should be submitted electronically as well):

- a) A detailed consolidated statement of comprehensive income per month. Please refer to Annexure A.
- b) A detailed statement of comprehensive income per benefit option per month. Please refer to Annexure A.
- c) A detailed consolidated year to date statement of comprehensive income. Please refer to Annexure B.
- d) Projected reserve level and solvency ratio.

It should be noted that until such time that the Risk Equalisation Fund (REF) legislation has been passed; no reference to it can/should be made by schemes in their business plan submission i.e. projections should not incorporate monies received / paid into REF.

### **2.8 Independent review**

The scheme may wish to seek the services of an expert to evaluate proposed changes, especially if they involve redesigning/ restructuring of benefit options. The evaluation sought must be addressed to the Board of Trustees of the scheme.

An evaluation can be performed by any person with the appropriate skills in statistics, health economics and actuarial science etc; and is not limited to an actuary.

The evaluation shall, at minimum, report on the appropriateness and adequacy of the following:

- a) Contributions, taking into account the level of benefits offered by the scheme.
- b) The level of contribution to be utilised towards reserve building.
- c) The level of non health expenditure.
- d) Brokerage commission.
- e) Overall risks faced by the scheme and the extent to which the scheme is vulnerable or covered against these risks.
- f) Sensitivity analysis.
- g) The effect on existing options (i.e. buy down/up to other options).



# **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

## **3. Annexures to the business plan**

### **3.1 Annexure A – specimen monthly statement of comprehensive income (consolidated and per option)**

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
<b>Net contribution income</b>													
<b>Relevant healthcare expenditure</b>													
Net claims incurred													
Claims incurred													
Third party claims recoveries													
Net income / (expense) on risk transfer arrangements													
Risk transfer arrangement fees / premiums paid													
Recoveries from risk transfer arrangements													
Profit / (loss) share arising from risk transfer arrangements													
<b>Gross healthcare result</b>													
Net income/(expense) on commercial reinsurance													
Commercial reinsurance premiums paid													
Recoveries from commercial reinsurance													
Profit / (loss) share arising from commercial reinsurance													
Managed care: management services													
Broker service fees													
Administration expenses													
Net impairment losses on healthcare receivables													
<b>Net healthcare result</b>													
<b>Other income</b>													
Investment income													
Income from use of own facilities by external parties													
Grants													
Sundry income													

## Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option

### Other expenditure

Asset management fees  
 Cost incurred in provision of own facilities  
 to external parties  
 Interest paid on savings accounts  
 Sundry expenses

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### Net surplus/(Deficit) for the year

### Other comprehensive income

Fair value adjustment on available for sale investments  
 Reclassification adjustment\*  
 Land and buildings revaluation

--

### Total comprehensive income for the year

--

\*The reclassification adjustment relates to gain/loss on sale of available-for sale investments which is taken to the income statement within "investment income".

Projected accumulated funds  
 Projected solvency ratio

Number of principal members  
 Number of beneficiaries  
 Pensioner ratio (65+ years)  
 Average age per beneficiary

## Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option

### 3.1. Annexure B – specimen year-to-date statement of comprehensive income

	Year 1	Year 2	Year 3
<b>Net contribution income</b>			
<b>Relevant healthcare expenditure</b>			
Net claims incurred			
Claims incurred			
Third party claims recoveries			
Net income / (expenses) on risk transfer arrangements			
Risk transfer arrangement fees / premium paid			
Recoveries from risk transfer arrangements			
Profit / (loss) share arising from risk transfer arrangements			
<b>Gross healthcare result</b>			
Net income / (expenses) on commercial reinsurance			
Commercial reinsurance paid			
Recoveries from commercial reinsurance			
Profit / (loss) share arising from commercial reinsurance			
Managed care: management services			
Broker service fee			
Administration expenses			
Net impairment losses on healthcare receivables			
<b>Net healthcare result</b>			
<b>Other income</b>			
Investment income			
Income from use of own facilities by external parties			
Grants			
Sundry income			
<b>Other expenditure</b>			
Asset management fees			
Cost incurred in provision of own facilities to external parties			
Interest paid on savings accounts			
Sundry expenses			
<b>Net surplus/(deficit) for the year</b>			

# **Guideline for the preparation of a business plan pursuant to an application for the registration of a new/restructured benefit option**

	Year 1	Year 2	Year 3
<b>Net surplus / (deficit) for the year continued</b>			
<b>Other comprehensive income</b>			
Fair value adjustment on available for sale investments			
Reclassification adjustment*			
Land and buildings revaluation			
<b>Total comprehensive income for the year</b>			

\*The reclassification adjustment relates to gain/loss on sale of available-for sale investments which is taken to the income statement within "investment income".

Projected accumulated funds  
 Projected solvency ratio

Number of principal members  
 Number of beneficiaries  
 Pensioner ratio (65+ years)  
 Average age per beneficiary