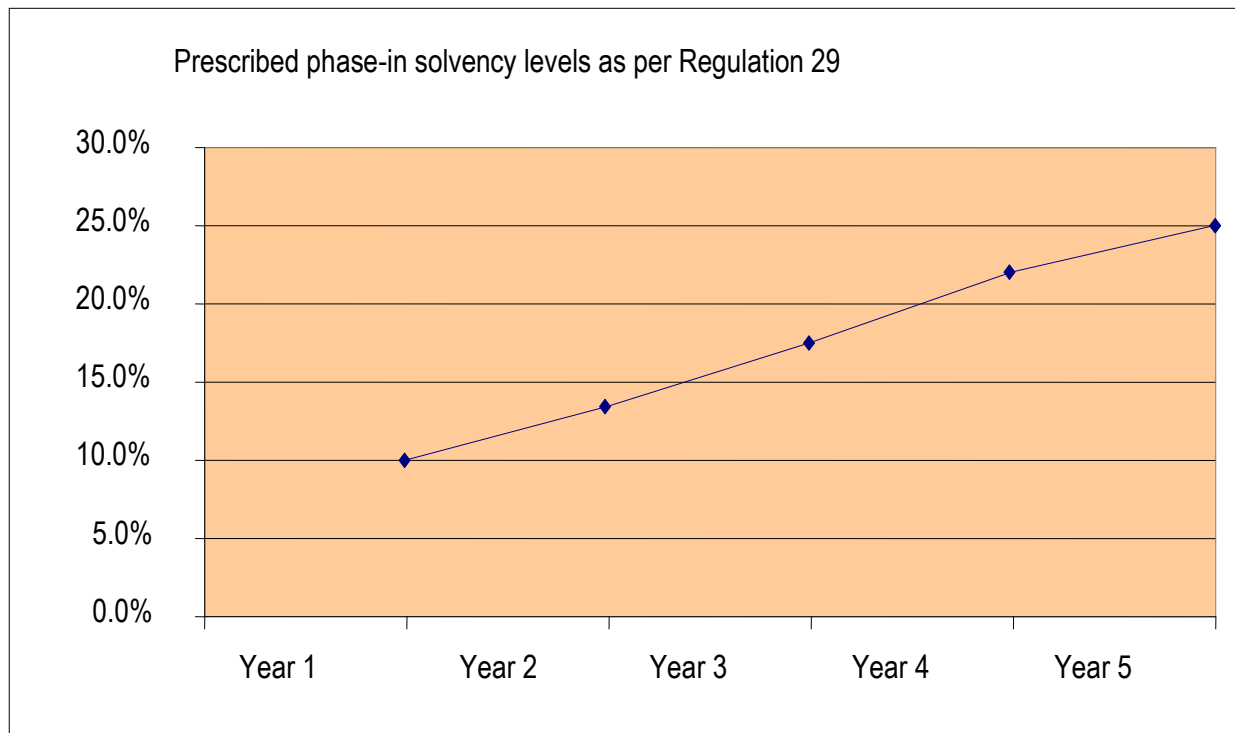




Guideline for the preparation of a business plan where a medical scheme is not meeting the statutory solvency requirements as per Regulation 29 of the Medical Schemes Act 131 of 1998, as amended



Guideline for the preparation of a business plan where a scheme is not meeting the statutory solvency requirements

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1. Introduction

Regulation 29(2) of the Medical Schemes Act 131 of 1998 (Act) states that a medical scheme must maintain accumulated funds when expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25.0%.

Regulation 29(3A) further indicates that a medical scheme which is registered for the first time after the coming into operation of the Regulations must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than:

- 10.0% during the first year after the scheme was registered;
- 13.5% during the second year;
- 17.5% during the third year; and
- 22.0% during the fourth year.

If a scheme is registered during the year, the first year of operation will be the following financial year. Therefore, if a scheme was registered on 15 July 2008, they need to obtain a 10.0% solvency level during the year ended 31 December 2009; as 1 January 2009 to 31 December 2009 will be the first full year of operation after the scheme was registered. From this follows that the solvency at year-end should not be lower than 10.0% and that the solvency level should not drop below this level during the subsequent year (2010).

In addition, Regulation 29(4) states:

“A medical scheme that for a period of 90 days fails to comply with sub regulations (2), (3) or (3A) must notify the Registrar in writing of such failure, and must provide information relating to-

- (a) the nature and causes of the failure, and
- (b) the course of action being adopted to ensure compliance therewith”.

The purpose of this document is to guide and assist medical schemes in submitting the information / business plan as is required by Regulation 29(4).

2. Business plan format

2.1. Executive summary

2.1.1. Nature and causes of failure

The scheme must supply detailed information relating to the nature and causes for failure to meet the required solvency level, which could include amongst others:

- Low/high membership growth.
- Change in demographic profile of membership.
- Under pricing of contributions.
- Comprehensiveness of the benefit options.
- Excessive claims.
- High non-healthcare expenditure

In supplying the reasons for the scheme's failure to comply with the minimum required solvency levels, the scheme must ensure that all relevant/appropriate information is disclosed to enable the Registrar to fully understand the exact nature and causes of the problems encountered by the scheme.

2.1.2. Course of action proposed to meet the required solvency

The scheme should provide the Office with all the actions to be taken by the Board of Trustees to ensure that the scheme complies with the minimum required solvency level in due course. Full details of the proposed action should be provided in the strategy and implementation as set out in part 2.3 of this document.

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The trustees should be specific regarding the timeframes within which the scheme will reach the minimum required solvency level of 25%.

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:

- Name and registration date of the scheme.
- The number and names of benefit options offered by the scheme.
- A brief description of the current options (objective of each individual option) and the target market (e.g. low cost).
- 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 on different income bands.
 - Family size.
- Developments within the scheme that have impacted solvency (e.g. previous amalgamations etc.).
- Names of participating employer groups (only major groups for open schemes).
- Name of administrator (only for third party administered schemes), including an organogram of the administrator and its related parties.
- Name of managed care provider(s) and services delivered, including an organogram of the managed care provider(s) and its related parties.
- Names and relationships with all related parties of the scheme, including an organogram where applicable.
- A full list of all the guarantees that the scheme has in place.

2.2.2. Governance of medical scheme

Every medical scheme shall have a Board of Trustees consisting of persons who are fit and proper to manage the business contemplated by the medical scheme in accordance with the applicable laws and the rules of the scheme (as stipulated in Section 29(1)(a) of the Act).

In this regard, the scheme should provide inter alia the following information:

- A brief description of the direct duties of the Board of Trustees as well as details regarding the constitution of the Board of Trustees i.e. the number of Board of Trustee members, their duties, terms of reference etc.
- A brief description of the sub-committees established in order to manage the scheme, for example audit committee, risk committee, remuneration committee etc.
- Details of the members and their responsibilities on these various committees.
- Investment strategy/policy of the scheme.
- The short and long term goals for the scheme/Board of Trustees.

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 being strengths and those being opportunities, as well as reasons why the scheme considers these factors as such, and in what way these factors will assist the scheme to perform satisfactorily.

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Possible strength/ opportunity factors could include, *inter alia* 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 turnaround as a result of type of system utilised; thus pleased members.
- Reduced administration expenditure per beneficiary, compared to the industry average.
- Stable risk pool due to younger, healthier members.
- Good investment strategy.
- Member communication.
- Good risk profile member growth.
- Compulsory membership.
- Advertising / branding.

The factors listed merely serve as an example of some of the strengths and opportunities that the scheme faces. Each scheme's circumstances will be different and schemes should not feel obliged to concentrate on or limit their analysis to only the above mentioned factors.

2.3.1.2. Weaknesses and threats

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

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

- Existence of competitive schemes and the resulting loss of membership.
- Poor risk pool 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 cost 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).
- Threat of HIV/Aids and other chronic diseases.
- Fraud and corruption.
- Quality of management information.
- Poor investment returns.

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.

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2.3.2. Market analysis

2.3.2.1. Membership/Target market strategy

If membership growth was identified as one of the courses of action to be adopted to improve the scheme's solvency level, the following minimum information (but not limited to) should be submitted with the business plan:

- A detailed marketing strategy.
- Analysis of main competitors (i.e. market comparison) including the reasons why they were chosen.
- Customer needs analysis.
- Forecast in terms of membership growth including reasonability testing.
- Detailed demographic profile analysis of current and projected beneficiaries (i.e. average age and pensioner ratio defined as 65 years and older).
- Illustrate the impact of the risk profile of the new members on the existing membership and the scheme's solvency level.
- The scheme's communication strategy (i.e. road shows, pamphlets, advertising etc).
- Letters of intent supporting the projected membership (growth).

2.3.3. Risk management

Risk management is a key area 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 provider or 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. The scheme can also refer to the relevant Guideline issued for more information on the submission of reinsurance contracts to the Office.

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

2.3.4. Pricing strategy

The pricing of the existing benefit options must be evaluated in order to establish the reason for solvency problems. In a case where (a) benefit option(s) is not financially sound, there might be a need to deregister or restructure the option(s). The scheme would then have to demonstrate how the resulting shift in membership to other options will affect its financial position and that of other options.

The scheme should also provide the composition of the current contributions per member/ per beneficiary per month per option and the underlying assumptions, together with the motivation for these assumptions. Information should be provided for at least the following:

- A description of the data used.
- Price inflation.
- Age adjustments.
- Utilisation adjustments.

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- Benefit changes.
- Non-healthcare expenditure.
- Investment return.
- Reserve loading.
- Demographic profile of member
 - Average age.
 - Pensioner ratio (65+ years).
 - Average family size.
 - Income profiles.
 - Chronic profile.
 - Buy-ups/downs.
- Subsidy (if any) assumptions and the impact thereof on the proposed contribution tables.

Amongst other factors, if a scheme has identified contributions to be under priced, they should provide details on how the problem will be resolved. This may be in the form of, amongst other things increasing contributions, reducing benefits, reducing non-healthcare expenditure, restructuring of options¹ or any other alternatives.

The scheme will therefore have to outline where possible, all those factors and their overall effect on the reserves of the scheme. Further, the resultant changes may or may not improve the existing solvency levels immediately, in that case, a synopsis of how and when the scheme intends restoring the solvency to the required level should be provided.

It should be noted that the Registrar prefers a graduated approach to a single extreme contribution increase or benefit cut.

2.3.5. Financial plan

The scheme must provide financial projections following the introduction of controls/ strategies aimed at improving the solvency and liquidity of the scheme. The projections must cover the number of years that it will take for the scheme to reach the minimum required solvency level. It should however be noted that the scheme will need to revise and resubmit their budgets if it is not in line with the initial plan.

Projections shall comprise of at least the following information in respect of all the years until the statutory solvency level is reached (this should be submitted in an excel workbook 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.
- e) Projected membership targets (both principal members and beneficiary numbers).
- f) Projected average age of beneficiaries, pensioner ratio (defined as 65 years and older) and family size per option.
- g) Sensitivity analysis, illustrating:
 - Impact of different membership mixes relating to the benefit options' different income bands on the projected solvency levels.
 - The impact of different membership targets on the projected solvency levels.

¹ Refer to the 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, for more detail on what additional information needs to be submitted in respect of the restructured options.

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- The impact of buy-downs/ups on the membership and projected solvency levels.
 - Impact of different risk profiles of members on the projected solvency levels.
 - The impact of different utilisation patterns on the projected solvency levels.
- h) All the projections should be accompanied by detailed assumptions:
- Membership growth rate and average family size.
 - Contribution per member/ beneficiary per month per the registered table.
 - Average contribution per principal member/ beneficiary per month.
 - A detailed calculation of claims costs on the basis of per member/ beneficiary per month. This should also include all assumptions used for year on year increases.
 - Inflation rates where applied. Please explain the use and need where different inflation rates were used.
 - Non-healthcare expenditure per member/ beneficiary per month. This should include a detailed breakdown of all non-healthcare expenditure per member/ beneficiary.
 - All reinsurance assumptions.

Once again, 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 needs to be submitted.

2.4. Independent review

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

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

Detailed calculations are required. The evaluation shall, at a 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- healthcare expenditure.
- d) Overall risks faced by the scheme and the extent to which the scheme is vulnerable or covered against these risks.
- e) Sensitivity analysis.

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3. Annexures to the business plan

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
Risk contribution income													
Relevant healthcare expenditure													
Net claims incurred													
Risk 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													
Gross healthcare result													
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													
Net healthcare results													
Other income													
Investment income													
Income from use of own facilities by external parties													
Grants													
Sundry income													
Other expenditure													
Asset management fees													
Cost incurred in provision of own facilities to external parties													
Interest paid on savings accounts													
Sundry expenses													
Net surplus/(deficit) for the year													

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
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

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Annexure B – specimen year-to-date statement of comprehensive income (consolidated and per option)

	Year 1	Year 2	Year 3
Risk contribution income			
Relevant healthcare expenditure			
Net claims incurred			
Risk 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			
Gross healthcare result			
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			
Net healthcare results			
Other income			
Investment income			
Income from use of own facilities by external parties			
Grants			
Sundry income			
Other expenditure			
Asset management fees			
Cost incurred in provision of own facilities to external parties			
Interest paid on savings accounts			
Sundry expenses			
Net surplus/(deficit) for the year			

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Year 1 Year 2 Year 3

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