Guideline for the preparation of a business plan pursuant to an application for the registration of a new medical scheme as per Section 22 of the Medical Schemes Act 131 of 1998, as amended.

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1 Introduction

Section 22 of the Medical Schemes Act 131 of 1998, as amended ("the Act") states:

a) "Any person who wishes to carry on the business of a medical scheme shall apply to the Registrar for registration under this Act.
b) An application under subsection (1) shall be accompanied by such documents and particulars as may be prescribed from time to time."

Regulation 2 of the Act furthermore sets out the information that should be included in the application for registration of a medical scheme and Regulation 2(l) specifically requires a detailed business plan.

The purpose of this document is to guide and assist applicants in preparing an application for approval of a new medical scheme, by the Registrar of Medical Schemes.

2 Business plan format

2.1 Objective

The applicant must supply sufficient information relating to the purpose of registering a new medical scheme. The application should include as a minimum the following:

- The need/purpose of the proposed medical scheme;
- The mission and objectives for registering the new medical scheme;
- Its target market; and
- The major differences between the proposed medical scheme and its competitors (existing medical schemes).

2.2 Medical Scheme Summary

2.2.1 Background information in respect of the new medical scheme

In accordance with Regulation 2, and the Council for Medical Schemes' requirements, the applicant should provide at least the following information:

- The full name under which the proposed medical scheme is to be registered;
- The date on which the proposed medical scheme is to come into operation;
- The physical and postal addresses of the registered office of the proposed medical scheme;
- Two copies of the rules of the proposed medical scheme, which must comply with Regulation 4(1) of the Act, and which are duly certified by the applicant as being true copies of the rules which will come into operation on the date of registration of the proposed medical scheme or date of commencement of the medical scheme, whichever date is applicable;
- The full names, physical and postal addresses and curriculum vitae of the principal officer and trustees of the proposed medical scheme; these curriculum *vitaes* should substantiate the fact that they are fit and proper persons to hold office at the new medical scheme;
- In the case of a restricted membership medical scheme, the name(s) of the participating employer(s), profession or industry;
- The name and address of the person who will administer the medical scheme; including an organogram of the administrator and its related parties;
- A copy of the administration agreement, where the proposed medical scheme is to be administered by an administrator;
- A copy of any other joint-administration agreement between the proposed medical scheme and any other party;

- A copy of any accredited managed healthcare agreements which the proposed medical scheme is planning to enter into;
- Guarantees and guarantee deposit vouchers as the Registrar may require;
- The name and addresses of accredited managed healthcare provider(s) and accredited managed healthcare services to be provided to the proposed medical scheme; including an organogram of the managed healthcare provider(s) and its related parties;
- A detailed statement of services to be undertaken, directly or indirectly, on behalf of the proposed medical scheme by an administrator, broker and/or managed care organisation;
- The name and address of the auditors of the proposed medical scheme;
- Details of any reinsurance contracts to be entered into by the proposed medical scheme. Reinsurance contracts are subject to approval by the Council for Medical Schemes (CMS) and the guideline to trustees for the submission of reinsurance contracts document is available from CMS' website;
- Names and relationships of all related parties to the proposed medical scheme, as well as all details regarding the delivering of any services by these related parties to the proposed scheme. The provision of an organogram might be necessary;
- A description of the proposed scheme's structure and corporate governance approach, which should include inter alia:
    - All the internal functions;
    - All the outsourced functions;
    - Composition of the board of trustees;
    - Details of sub-committees (i.e. terms of reference, composition);
    - Details regarding the new scheme's conflict of interest policies and procedures; and
    - Details regarding the training of trustees/steering committee members.
- Proof of payment of the registration fees as prescribed by Regulation 31(a) and (b) of the Act.

2.3 Strategy and implementation

2.3.1 SWOT analysis

Strength

The scheme must give a brief overview of factors considered to be its strengths, and in which way will these factors increase the scheme's competitiveness:

Possible strengths could include, inter alia the following:

- A competitive product offering, benchmarking the scheme's benefit options with its competitors;
- Effective risk management (e.g. capitation arrangements with managed care networks; internal controls etc);
- Efficient claims processing turnaround times as a result of quality systems utilised; thus, please members;
- Reduced administration expenditure per beneficiary compared to the industry average;
- Good investment strategy;
- Strong reserves;
- Effective communication with members;
- Good risk profile membership; healthy, lower average age compared to the industry, lower pensioner ratios;
- Compulsory membership; and
- Effective marketing strategies / strong brand.

Opportunities

What opportunities are available in the market which can be explored.

Possible opportunities could include, inter alia, the following:

- Target potential members not currently on medical scheme;
- Development of relationships with potential employer groups to offer employees the scheme as an option;
- National Health Insurance (NHI).

These are examples of factors the scheme can consider to be its strengths and opportunities and therefore not exhaustive.

Weaknesses

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

Factors that considered to be weaknesses could include but are not limited to the following:

- Poor risk pool due to higher age profile of members and higher pensioner ratio;
- Higher than average claims pattern;
- Dissatisfied members due to late claims processing and payments;
- Failure to attract sufficient members to increase the size of the risk pool;
- Fraud and corruption;
- Poor internal controls;
- Quality of management information; and
- Poor investment returns.

Threats

Factors considered to be threats should be provided. The scheme should also indicate how it plans to address those threats.

Factors could include but are not limited to the following:

- Existence of competitor schemes and the resulting loss of membership.
- 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;
- Substitute products, i.e. insurance contracts, National Health Insurance (NHI);

The above are examples of factors which could affect the survival of a medical scheme and therefore not exhaustive.

2.3.2 Membership/Target market strategy

Projections should be made in terms of the proposed membership of the new scheme, including the projections per benefit option.

The applicant should also indicate the target market (i.e. public servants, low income earners, professionals etc.) for the new medical scheme and indicate clearly how they intend to attract such membership. The applicant should submit at least the following information per option:

- Five-year forecast in terms of membership growth, including sensitivity testing;
- Average age of the beneficiaries, including the pensioner ratio (defined as 65 years and older). This information should be on a consolidated level as well as on a per option level;
- Geographical area of the projected members, if relevant;

- Projected average family size of the proposed members per option;
- If the proposed contribution tables differentiate between income bands, the applicant should indicate the number of members estimated per income band. If the scheme's contribution tables do not provide for income bands, an indication of the salary income bands of the proposed target market should be provided;
- A detailed marketing and communication strategy indicating how and by when the new medical scheme will achieve the minimum number of 6 000 principal members. It is important to note that Regulation 2(3) of the Act requires that a new scheme obtains the minimum number of principal members within a period of three months of registration of the medical scheme. The applicant should also indicate which channels will be used to communicate to its target market (i.e. employer group, trade unions, brokers etc.);
- Member needs analysis;
- The applicant should compare the new scheme's target market to the industry and determine whether the new medical scheme will be attractive to the proposed target market, compared to its competitors; and
- The applicant should provide any letter(s) of intent by prospective employers, if applicable. In the case where expected members are covered by other schemes, the specific medical schemes should be detailed.

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

Furthermore, the scheme is required to provide its estimated membership mix. Below is an example of how the proposed scheme's options could illustrate its membership mix:

Membership mix	Average members	% of average members	Average beneficiaries	% of average beneficiaries
Option 1				
R0 - R1 000				
R1 001 – R3 000				
R3 001 – R5 000				
R5 000 plus				
Option 2 (no income bands)				
Total scheme				

2.3.3 Market comparison

The applicant should furthermore submit a detailed comparison with the competitors of the proposed new scheme. The following information should, as a minimum be included in the analysis:

- 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; and
  - Network/capitated.
- Differentiation in respect of structure of benefits:
  - Traditional;
  - New generation; and
  - Network.

- Comparison of contributions.

The table below merely serves as an example and should be adjusted to be relevant for the scheme's options, compared to options offered by its peers' options:

Name	New medical scheme Option 1	Medical scheme – Peer A Option 1	Medical scheme – Peer B Option 5
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	R3 000 per member per month R1 000 per beneficiary per month	R2 500 per member per month R2 200 per beneficiary per month	R3 100 per member per month R1 300 per beneficiary per month
In-hospital benefits (overall limits & rate)	Unlimited	Unlimited	R2 000 000 per family per annum
Out-hospital benefits (overall limits & rate)	Unlimited	Limited to scheme rate	Limited to 200% of scheme rate
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

2.4 Benefit design

The applicant should provide for the following information regarding its proposed benefit options:

- The number and names of the proposed benefit options to be registered;
- The main objectives of the different benefit option(s) (i.e. illustrating the uniqueness of the proposed options);
- The benefit structure of the benefit option(s) as well as the main objective/purpose for the registration of such option(s); and
- A summary of the membership profile per option. For example:
  - Average age;
  - Family size;
  - Pensioner ratio (65+ years); and
  - Chronic profile.

Below is an example of how the proposed scheme's options could be summarised:

Option 1	Option 2
Traditional option	Traditional option
Income bands: · R0 - R1 000 · R1 001 – R3 000	No income bands

Option 1	Option 2
· R3 001 – R5 000 · R5 000 plus	
Average family size: 2.7	Average family size: 2.5
Average age: 27.4 yrs	Average age: 28.6 yrs
Pensioner ratio: 2.9%	Pensioner ratio: 3.4%
No. of chronic beneficiaries: 35.1%	No. of chronic beneficiaries: 23.2%
Average contributions: · R2 000 per member per month · R1 000 per beneficiary per month	Average contributions: · R2 200 per member per month · R1 200 per beneficiary per month
No overall hospital limit 200% of scheme rate sub limits applicable	No overall hospital limit 100% of scheme rate sub limits applicable
No Threshold	Threshold: B= R5 300 F= R8 800
Chronic conditions Formulary PMB	Chronic condition Formulary extended limited to: · R6 000 pb · R12 000 pf
General practitioners - Unlimited	General practitioners – Limited to 20 visits per family
Specialist services – Unlimited	Specialist services – Limit of R50 000 per family
Surgical procedures – limit of R20 000 per family	Surgical procedures – No benefit

pf = per family
pb = per beneficiary
PMB = Prescribed Minimum Benefits
B = Beneficiary
F = Family

2.5 Pricing strategy

2.5.1 Contributions

The applicant should provide details of its proposed contribution tables per option, as well as the underlying assumptions used in the pricing of the contributions.

Option 1

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

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)			

Option 2

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

	Member	Adult dependent	Child dependant
Option 2			
Risk contributions			
savings contributions			

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

The following table depicts the distribution of contributions received:

Description	Option 1			Option 2		
	pmpm	pbpm	% of GC	pmpm	pbpm	% of GC
Risk portion – healthcare related						
Risk portion – non-healthcare related						
Savings portion						
Contribution to reserves/investment income						
Total proposed premium per month						

pmpm = per member per month
pbpm = per beneficiary per month
GC = Gross Contribution

The detailed motivation for each assumption above should be included. The following are a few examples of assumptions to be documented:

- Description of data used;
- Price inflation;
- Age adjustments;
- Benefit;
- Expected utilisation;
- Accredited managed healthcare services;
- Non-healthcare expenditure;
- Investment return;
- Reserve loading;
- Demographic profile of members:
  - Average age;
  - Pensioner ratio (65+ years);
  - Average family size per option;
  - Chronic profile;
  - Income profile; and
- Subsidy (if any) assumptions and the impact on the proposed contributions table.

This merely serves as a guide and is not in any way exhaustive of the assumptions that may be used. A detailed explanation of both the assumptions and the basis or impact of the assumptions on the financial position will prove useful.

2.5.2 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 individual's income (e.g. 22.5% of an individual's income (monthly) will go towards medical aid contributions), the level of the employer subsidy. The scheme must also give an indication of how many members receive employer subsidies and quantify the impact of the subsidy on a member and the affordability of contributions.

	Option 1		Option 2	
		% of salary		% of salary
Contribution per member per month	R400		R800	
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	R300		R600	
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%

2.5.3 Benefits

The projected claims costs for each benefit option should be listed in the business plan on a per member / beneficiary per month basis, as well as a percentage of risk contribution income. The following is an example of the minimum information to be disclosed:

Pricing of contribution	Option 1			Option 2		
Year Start	pmpm	pbpm	% of RCI	pmpm	pbpm	% of RCI
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						
Total benefit						

pmpm – per member per month
pbpm – per beneficiary per moth
RCI – Risk Contribution Income

The level of any co-payments should also be disclosed.

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 as stated in 2.2.1. The capitation fee paid should also be justified i.e. demonstrable value for money.

2.5.4 Non-healthcare expenditure

The applicant should perform a detailed analysis of the non-healthcare expenditure per benefit option, expressed as a percentage of risk contribution income and on a member / beneficiary per month basis. For example:

Non-healthcare expenditure	Option 1			Option 2		
	pmpm	pbpm	% of RCI	pmpm	pbpm	% of RCI
Administration expenditure						
-Administration fees						
-Other administration expenditure						
Broker fees						
Commercial reinsurance						
Impairment losses						
Total						

pmpm – per member per month
pbpm – per beneficiary per moth
RCI – Risk Contribution Income

Details of the other administration costs should also be provided. If administration costs (administration fee plus other administration expenditure) exceed 10% of gross contributions, and or also higher than the industry averages in terms of pabpm an explanation should be provided.

2.5.5 Reserve building

The applicant should indicate the extent to which the net operations will contribute to reserve building and clearly state how the new medical scheme will meet the following solvency requirements as per Regulation 29(3A) of the Act:

- 10.0% - during the first year after the scheme was registered;
- 13.5% - during the second year;
- 17.5% - during the third year;
- 22.0% - during the fourth year; and
- 25.0% - from the fifth year onwards.

Details of the scheme's reserve policy should also be provided.

It is also useful to analyse the impact on the proposed scheme's reserves (sensitivity analysis) using different scenarios for example:

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

The above-mentioned analysis could be summarised as follow:

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

A break-even analysis illustrating the minimum required income to cover all claims and non-healthcare 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 new scheme plans to minimise its exposure to risk can take countless forms that could include any of the following:

- Risk transfer arrangements with managed healthcare providers where an element of risk is transferred to the provider or is shared between the new 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; and
- 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 Council for Medical Schemes.

The applicant should provide full details of possible risk management tools to be implemented. Any proposed risk sharing arrangements should be supported by appropriate reasons for the implementation thereof (i.e. need analysis).

2.7 Financial plan

The applicant should provide details of the financial projections of the overall scheme and per option. The projections should cover a period of at least five full calendar years.

Projections shall comprise of at least the following information (this should also be submitted electronically in an excel workbook):

- A detailed consolidated statement of comprehensive income per month for the first year of operation. Please refer to Annexure A;
- A detailed statement of comprehensive income per benefit option per month for the first year of operation. Please refer to Annexure A;
- A detailed consolidated year to date statement of comprehensive income for 5 years or up to whenever the scheme expects to reach the required solvency margin. Please refer to Annexure B;
- Projected reserve level and solvency ratio for 5 years or up to whenever the scheme expects to reach the required solvency margin;
- Projected consolidated cash flow statement. Please refer to Annexure C; and
- Projected cash flow statement per month for the first year of operations. Please refer to Annexure D.

2.8 Independent review

The applicant may wish to seek the services of an expert to evaluate some aspects, especially with regards to the proposed benefit design of the new medical scheme. The evaluation sought must be addressed to the Board of Trustees/steering committee of the proposed scheme.

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

The evaluation should at a minimum report on the appropriateness and adequacy of the following:

- Contributions, taking into account the level of benefits offered by the proposed scheme;
- The level of contribution to be utilised towards reserve building;
- The level of non-healthcare expenditure;
- Overall risks faced by the proposed scheme and the extent to which the proposed scheme is vulnerable or covered against these risks; and
- Sensitivity analysis (refer to paragraph 2.5.5 for examples of various scenarios).

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
Risk contribution income													
Relevant healthcare expenditure													
Net claims incurred													
Risk claims incurred													
Third party claims recoveries													
Accredited managed healthcare services (no risk transfer)													
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													
Broker service fees													
Administration expenses													
Net impairment losses: trade and other receivables													
Net healthcare result													
Other income													
Investment income													
Income from use of own facilities by external parties													
Grants													
Sundry Income													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
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													
Other comprehensive income													
Fair value adjustment on available for sale investments/investments held at FVOCI													
Reclassification adjustment*													
Land and buildings revaluation													
Other (Specify)													
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

3.2 Annexure B - specimen year to date statement of comprehensive income (consolidated and per option)
(Please note that the scheme should provide forecasts until they reach the minimum solvency level of 25%)

	Year 1	Year 2	Year 3
Risk contribution income			
Relevant healthcare expenditure			
Net claims incurred			
Risk claims incurred			
Third party claims recoveries			
Accredited managed healthcare services (no risk transfer)			
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			
Broker service fees			
Administration expenses			
Net impairment losses: trade and other receivables			
Net healthcare result			
Other income			
Investment income			
Income from use of own facilities by external parties			
Grants			
Sundry Income			

	Year 1	Year 2	Year 3
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			
Other comprehensive income			
Fair value adjustment on available for sale/ investments held at FVOCI investments			
Reclassification adjustment*			
Land and buildings revaluation			
Other (Specify)			
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

3.3 Annexure C – specimen for year to date cash flow statement

	Year 1	Year 2
Cash flows from operating activities		
Cash receipts from members		
Cash paid to providers and members		
Cash generated from operations		
Interest paid		
Other (specify)		
Net cash from/ (used in) operating activities		
Cash flows from investing activities		
Purchase of property, plant and equipment		
Proceeds from disposal of property, plant and equipment		
Purchase of investment property		
Proceeds on disposal of investment property		
Purchase of investments		
Proceeds on disposal of investments		
Interest received		
Dividend received		
Rentals received		
Other (specify)		
Net cash from/ (used in) investing activities		
Cash flows from financing activities		
(Repayments)/increase in borrowings		
Other (specify)		
Net cash from/(used in) financing activities		
Net increase in cash and cash equivalents		
Cash and cash equivalents at the beginning of the year		
Cash and cash equivalents at the end of the year		

3.4 Annexure D – specimen monthly cash flow statement

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Cash flows from operating activities													
Cash receipts from members and providers													
Cash paid to providers, employees and members													
Cash generated from operations													
Interest paid													
Other (specify)													
Net cash from/(used in) operating activities													
Cash flows from investing activities													
Purchase of property, plant and equipment													
Proceeds from disposal of property, plant and equipment													
Purchase of investment property													
Proceeds on disposal of investment property													
Purchase of investments													
Proceeds on disposal of investments													
Interest received													
Dividend received													
Rentals received													
Other (specify)													
Net cash from/(used in) investing activities													
Cash flows from financing activities													
(Repayments)/increase in borrowings													
Other (specify)													
Net cash from/(used in) financing activities													

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Net increase in cash and cash equivalents													
Cash and cash equivalents at the beginning of the year													
Cash and cash equivalents at the end of the period													