



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.

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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 –

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

Some of the changes the CMS consider or define as restructured are:

- Structure change e.g. Traditional to New Generation or Capitation to Hospital or major benefit change; and
- Efficiency discount options.

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

2 Business plan format

2.1 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 is intending to fill in the scheme's current options structure);
- 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); and
- The new/restructured option(s) must comply with the provisions of Section 33 of the Medical Schemes Act.

When 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 considered in the design, marketing, and implementation of the benefit option.

The scheme will therefore have to outline where possible, all those factors and its 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 included.

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 the benefit options currently offered by the scheme.

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- 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).
- 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; and
 - Racial classification
- Developments within the scheme over the past few years (i.e. previous amalgamations).
- Name of participating employer groups (only major groups for open schemes).
- Name of administrator (only for third party administered schemes), including organogram of the administrator and its related parties.
- Name of accredited managed healthcare provider(s) and accredited managed healthcare 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; and
- A full list of all the guarantees that the scheme has in place.

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 these factors increases the scheme's competitiveness.

Possible strengths could include, inter alia the following:

- A competitive product offering, benchmarking the scheme's products with its competitors.
- Effective risk management (e.g. capitation arrangements with managed care networks; internal controls etc).
- Efficient claims processing because of quality systems utilised.
- 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 branding.

Opportunities

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

Possible opportunities could include, inter alia the following:

- Target potential members not on medical scheme using the current options or introducing new options.
- Improved/increased product offering because of the new/restructured option.
- Development of relationships with potential employer groups to offer employees the scheme as an option.
- Policy and legislation changes.

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

Weaknesses

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 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 competing options offered by other 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. Policy and legislation changes

The above is an example of factors which could affect the survival of a medical scheme and therefore not exhaustive.

2.4 Benefit option

2.4.1 Benefit design for a new/restructured option

A benefit option is regarded as restructured when there is a change in the material structure. For example, the table below depicts an example of a restructured benefit option, where the currently registered option is a traditional option (offers day-to-day benefits from the risk pool). The option is subsequently restructured into a new generation hospital plan by removing the day-to-day benefit.

The following table is a summarised example of how a benefit option may be restructured:

Name	Currently Registered Option D	Restructured Option D
Type	Traditional	New generation
Income bands (per rules or per target group/market)	< R 1000 R 1 000 – R3 000	< R 1000 R 1 000 – R3 000

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Name	Currently Registered Option D	Restructured Option D
	R3 001 – R5 000 > R5 000	R3 001 – R5 000 > R5 000
Average Contributions per member per month	R3 000 per member per month	R2 200 per member per month
- per beneficiary per month	R2 000 per beneficiary per month	R1 100 per beneficiary per month
Average family size	2.7	2.7
In-hospital benefits (overall limits & rate) PMB Non PMB	Unlimited Unlimited	Unlimited Unlimited
Day-to-Day	R10 000 pfpa	None
Out-hospital benefits (overall limits & rate) PMB Non PMB	Unlimited Limited to 200% of scheme rate	Unlimited None
Personal Medical Savings Accounts	N/A	Compulsory 25.0%
Average age	27.4	27.4
Pensioner ratio	2.9%	2.9%
No. of chronic beneficiaries	35.1%	35.1%

pfpa: per family per annum

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

Details on the 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.

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Existing Option A	Existing Option B	New Option C	Restructured Option D
No overall hospital limit 200% of scheme rate Sub limits applicable	No overall hospital limit 100% of scheme rate sub limits applicable	R500 000 overall hospital limit per family 100% scheme rate within a network hospitals R500 deductible is payable for certain procedures	R200 000 overall hospital limit per family 100% scheme rate within a network hospitals sub limits applicable
No Threshold	Threshold: B= R5 300 F = R5 500	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

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

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 because of the restructuring. There should be adequate differentiation between registered and new/restructured options for them to be registered.

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).

2.5 Market analysis

2.5.1 Membership/Target market strategy

The scheme must project membership for the proposed 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.
- Demographic profile of the current and projected beneficiaries (i.e. average age, chronic profile, 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.

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- 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 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 used to ensure that actual experience reflects the expected movements assumed in the point above, as well as the mitigating factors 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; and
- 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 which should be reached within 3 months.

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

Membership Mix	Average members	% of average members	Average beneficiaries	% of average beneficiaries
Option A < R 1000 R1 0000 – R3 000 R 3 0001 – R5 000 > R 5000				
Option B (no income bands)				
Option C < R4 000 > R4 000				
Option D <R2 500 >R2 500				
Total scheme				

2.5.2 Market comparison

The scheme should furthermore submit a detailed competitive comparison with the primary competitors of the proposed new/ restructured option. 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

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- Comparison of contributions.

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

Name	New/restructured Option C	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

2.6 Pricing strategy

2.6.1 Contributions

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

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

Option C:

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:

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Option D:

	Member	Adult dependent	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 based on per member / per beneficiary per month.

The following tables depict the minimum information to be disclosed:

Description	Option C			Option D		
	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 contribution per month						

pmpm= per member per month

pbpm= per beneficiary per month

GC = Gross Contribution

The assumptions to the above figures and calculations should also be provided per benefit option, together with motivation for these assumptions. The following are a few examples of assumptions to be documented:

- Description of data used.
- Price inflation.
- Age adjustments.
- Benefit changes.
- Utilisation adjustments.
- 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.
- Buy-downs/ups; and
- Subsidy (if any) assumptions and the impact on the proposed contributions table.

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

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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.

2.6.2 Affordability of contributions

Should an option 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 scheme must also give an indication of how many members receive employer subsidies as well as the level of the employer subsidy. The impact of the employer subsidy on a member and affordability should be quantified.

	Option C		Option D	
		% 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 member 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%

2.6.3 Benefits

The projected claims costs for the new/ restructured 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. 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:

Pricing of contribution	Option C			Option D		
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						

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Pricing of contribution	Option C			Option D		
Year Start	pmpm	pbpm	% of RCI	pmpm	pbpm	% of RCI
PMB						
Non-PMB						
Total benefit						

pmpm=per member per month

pbpm=per beneficiary per month

RCI = Risk 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 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:

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

B = beneficiary

F = family

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2.6.4 Non-healthcare expenditure

Details of the new/restructured option's non-healthcare expenditure, expressed as a percentage of risk contribution income and on a per member per month / per beneficiary per month basis, must be provided. For example:

Total non-healthcare expenditure	Option C			Option D		
	pmpm	pbpm	% of RCI	pmpm	pbpm	% of RCI
Administration expenditure						
- Fees in respect of accredited administration services						
- Fees to accredited administrator in respect of other administration services						
- Other administration expenditure						
Broker fees						
Commercial reinsurance						
Impairment losses: Trade and other receivables						
Total						

pmpm = per member per month

pbpm =per beneficiary per month

RCI =Risk Contribution Income

Details of the other administration costs should also be specified. If administration costs (administration fees plus other administration expenditures) exceed 10% of gross contributions, an explanation should be provided.

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

The above-mentioned analysis could be summarised as follows:

Scenario	% change in insured 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.

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2.7 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 accredited managed healthcare 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.
- Accredited managed healthcare arrangements (no risk transfer) are entered into to ensure both the provision of high level of quality of care and controlling the cost thereof; 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 scheme should provide full details of possible risk management tools to be implemented in respect of the new/restructured benefit option. Any proposed risk sharing arrangements should be supported by appropriate reasons for the implementation thereof (i.e. needs analysis).

2.8 Financial plan

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 in an excel workbook as well):

- A detailed consolidated statement of income per month, for the first year. Please refer to Annexure A.
- A detailed statement of income per benefit option per month, for the first year. Please refer to Annexure A.
- A detailed consolidated year to date statement of income. Please refer to Annexure B; and
- A detailed demonstration of the savings achieved by the proposed efficiency discount options (if applicable).

2.9 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.

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

- Contributions, considering the level of benefits offered by the scheme.
- The level of contribution to be utilised towards reserve building.
- The level of non - healthcare expenditure.
- Overall risks faced by the scheme and the extent to which the scheme is vulnerable or covered against these risks.
- Sensitivity analysis; and
- The effect on existing options (i.e. buy down/up to other options).

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3 Annexures to the business plan

3.1 Annexure A - specimen monthly statement of 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 (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 Expenditure													
Fees in respect of accredited administration services													
Fees to accredited administrator in respect of other administration services													
Other administration expenditure													
Net impairment losses on trade and other receivables													
Net healthcare result													
Other income													
Investment income													
Income from use of own facilities by external parties													
Grants													
Sundry Income													

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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

	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													

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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3.2 Annexure B - specimen year to date statement of 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 (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 Expenditure			
Fees in respect of accredited administration services			
Fees to accredited administrator in respect of other administration services			
Other administration expenditure			
Net impairment losses on trade and other receivables			
Net healthcare result			
Other income			
Investment income			
Income from use of own facilities by external parties			
Grants			
Sundry Income			

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	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			

Projected accumulated funds
Projected solvency ratio

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