

COUNCIL FOR MEDICAL SCHEMES

**REVIEW OF THE FACTORS THAT
INFLUENCE FINANCIAL SOUNDNESS OF
MEDICAL SCHEMES**

DISCUSSION PAPER

***OFFICE OF THE REGISTRAR OF MEDICAL SCHEMES
APRIL 2003***

1. INTRODUCTION

The Medical Schemes Act no 131 of 1998 (the Act) was promulgated and brings all entities that conduct the business of a medical scheme under its ambit. The provisions of this Act constitute a significant departure from the provisions of the previous Act in many ways.

Whereas this Act has numerous significant provisions, one of the most important sections prescribes a minimum level of accumulated funds that medical schemes are required to maintain. The main purpose of this requirement is to act as a cushion should a scheme experience unexpected high levels of expenditure. Such unexpected variations in the levels of claims may result in much higher expenditure than contributions can meet. The result may well be a shortfall in the schemes' reserves to meet claims.

The prescribed minimum reserves requirement seeks to ensure that schemes have enough reserves to withstand these unexpected shocks until corrective action can be taken. This in turn ensures that scheme members continue to have sufficient confidence that their claims will be met.

Regulation 29 sets the minimum accumulated funds to be maintained, by a medical scheme, as a proportion of gross annual contributions at 25%. There are phase in provisions to 31 December 2004. These phase-in provisions extend to newly registered schemes.

The introduction of this Act met with a lot of commentary from the industry. One of the areas most commented on was this requirement to maintain a minimum level of accumulated funds.

After consideration of the commentary and the identification of certain technical issues, The Registrar of Medical Schemes decided to form a focus group to address and advise on these areas.

2. FINANCIAL SOUNDNESS FOCUS GROUP

The Financial Soundness Focus Group was established and had its first meeting in December 2001. The establishment of this focus group was informed by the following factors:

- It was necessary to have a group that was small enough in order to be able to expedite the discussions.
- It was necessary to involve organisations that represent relevant professions so that technical issues can be dealt with robustly.
- It was necessary to involve bodies that are representative of medical schemes' interests and views.
- The group was envisaged to be advisory in nature.

Invitations were extended to the following organisations for reasons enunciated above:

- The Actuarial Society of South African (ASSA)
- The Board of Healthcare Funders (BHF)
- The South African Institute of Chartered Accountants (SAICA)
- Open Medical Schemes Forum (OPMS). This group joined later in 2002.

A Council member chairs the focus group, and the Registrar's office staff form part thereof.

Initially, the group was formed as a solvency (accumulated funds/reserves) focus group. After initial discussions, it was felt that the group's mandate was bigger than the narrow focus on solvency. It had to look at the general financial soundness of medical schemes. The main purpose of the focus group therefore is to promote financial soundness principles of medical schemes by investigating issues raised in the manner that the minimum accumulated funds requirement is managed, and any other related matters.

3. PURPOSE OF THIS REPORT

Whereas the Financial Soundness Focus Group has discussed the issues around the financial soundness of medical schemes and the solvency calculation in particular, it

has always been the Registrar's opinion that these issues require to be canvassed with the industry stakeholders in general. The purpose of this report is to solicit such industry-wide stakeholder comment.

It should be pointed out that the report has been prepared with a reader in mind who is *au fait* with medical scheme issues. This was done in the interest of brevity.

The document will be available for public comment from the 1st April 2003 to 30th April 2003. During this period all written comments should be forwarded as follows:

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4. REPORT FORMAT

This report has been written in the following structure:

- The issue* The basic problem/issue is identified and discussed. All the viewpoints that have been raised within the Financial Soundness Focus Group are discussed here, even if they differ from the official position.
- Registrar's view* This represents the official position of the Registrar of Medical Schemes on the issue at present. This includes situations where the position is indeterminate at this point and discussion on the matter is on going.
- Comment focus* All stakeholders are requested to comment on the issues raised on this document. There is no restriction on the nature, type and scope of comments, except of course to address the issue as identified above. This section merely suggests the area of focus that the Registrar is particularly interested that the comments should address.

5. ISSUES PERTAINING TO THE CALCULATION OF THE SOLVENCY REQUIREMENT

5.1 Inadequate contributions setting and lack of statutory professional supervision

The issue

The key issue here relates to the impact that poor contributions setting has on the solvency requirement. If a medical scheme has set contributions that turn out to be inadequate and do not meet the levels of the scheme's expenditure, a perverse situation arises if no adjustment is required in the manner that the required reserves level is calculated. The reasons for the inadequate contributions may vary from deliberate under-pricing, for marketing reasons, to unexpected demographic profile changes that occur after the pricing exercise.

Let us illustrate this point by way of an example. Let us assume scheme A and B are facing exactly the same level of total expenditure, say R150 over a year. Scheme A sets contributions such that it receives R170 and scheme B sets the contributions such that it receives only R100 during the same period. The requirement to determine statutory reserves as a percentage of annual contributions results in scheme A being required to meet a higher level of reserve requirements of $(R170 \times 25\%)$ R42.50 whereas scheme B would only be required to hold $(R100 \times 25\%)$ R25. This result is clearly perverse because the scheme that is incurring deficits is required to hold less statutory reserves than the scheme that has set contributions at appropriate levels.

The lack of statutory requirement for independent professional supervision in the process of setting contributions has been identified as constituting a problem. This is usually contrasted with other regulated financial sectors, where there is a statutory requirement for retirement funds to appoint an actuary for instance. It has been pointed out that contribution setting is a function that requires a qualified and experienced person to perform. Statutory professional supervision would provide trustees with the benefit of such qualifications and experience. It is noteworthy that the Registrar of Medical Schemes may, at his discretion, call for an actuarial report in this regard.

It has also been suggested that there is room for increased regulatory supervision of contribution setting of medical schemes.

It has also been pointed out that contribution setting is an on-going exercise that doesn't end once the contribution tables have been fixed at the beginning of each year. There is a need to review the results shortly after the introduction of the new contribution tables. The end of the first quarter has been mooted in this regard.

Registrar's view

At this stage the Actuarial Society of South Africa (ASSA) is the only organisation representing professionals, which ordinarily advises trustees on pricing, which has established liaison with the Council for Medical Schemes on this matter. It has been agreed that ASSA will develop professional guidance on pricing, in conjunction with the Council for Medical Schemes. It is envisaged that this professional guidance note, having been canvassed between ASSA and the Council, will be underwritten by the Council for Medical Schemes. This same process is followed with SAICA in the development of the Accounting and Auditing Guide. The effect of this underwriting by the Registrar's office will be that all schemes will have to comply therewith.

This process does not in any way seek to preclude other professional bodies from seeking to canvass that their members perform a pricing exercise. However, any such endeavour would have to be preceded by a process in terms of which acceptable professional standards, relating specifically to the exercise of setting pricing for medical schemes, are set and approved. Members of such professional bodies would have to comply with these professional standards.

ASSA will also issue practicing certificates to their members, which will provide assurance that the member is appropriately experienced in the South African medical schemes industry business.

Our view is that a statutory requirement for the appointment of an actuary for medical schemes is inappropriate at this point.

Comment focus

- The issue identified and the position taken regarding the development of professional guidance by ASSA.
- The general question of professional supervision for medical schemes.

5.2 Definition of Reserves

The issue

A review of financial statements, especially those submitted to the Registrar's office for years prior to 2001, revealed a number of problematic grey areas in the definition of reserves. Essentially, there were reserves whose description lent themselves to their exclusion from accumulated funds, sometimes incorrectly so, because they were regarded as being set aside for specific purposes. Examples such as contingency reserves, AIDS reserves, etc. were quite common amongst some medical schemes' financial statements. The exclusion from accumulated funds of these reserves resulted in an understated rather than the true level of calculated statutory reserves. The effect was that some schemes appeared not to meet the required reserves level when in fact they did.

The Registrar of Medical Schemes issued Circular 13 in March 2001 to clear up this matter. Essentially, the position is that all reserves that have been "set aside" for claims related purposes will be treated as accumulated funds. This brings such reserves within the net, as it were. The circular further discouraged schemes from the use of such descriptions that may be misinterpreted and encouraged the use of the accumulated funds description.

The South African Institute of Chartered Accountants revised the Accounting and Auditing Guide for Medical Schemes to address this matter, amongst others, the latest revision having been launched in March 2003. There is a feeling that after this revision the accounting guide, endorsed by the Registrar for Medical Schemes, has given attention to the wording used in preparing financial statements, and has clarified what really constitutes reserves set aside for specific purposes.

The review of financial statements submitted for the 2001 financial year indicates a significant improvement in this regard.

Registrar's view

Whereas from time to time an odd situation presents itself where consideration of the true nature of the reserve has to be determined, these cases are now very rare. Usually the pre-funding reserves fall into this category. The true nature of these reserves gets determined from the scheme and adjustments are made if necessary. This issue is not considered a problem anymore.

Comment focus

Any grey areas lurking out there that still need to be determined whether they are accumulated funds or reserves set aside for specific purposes.

5.3 Inadequate IBNR liabilities

The issue

Section 35 (9)(b) of the Medical Schemes Act requires medical schemes to include in their liabilities an estimate of claims that have been incurred but not yet reported (IBNR) in the financial statements.

Because the exact amount of this liability is not known at the time of preparing financial statements, it has to be estimated. This will be the case especially if the financial statements are prepared soon after the end of the financial period.

If a medical scheme has underestimated this liability, the reported reserves position of the scheme may be artificially high. Whereas this understatement may be an honest error, this involvement of judgement may also lead to manipulation. Schemes may understate the liabilities in order to create an impression of reserves that do not actually exist. A perverse situation arises in that a conservative scheme may appear not to meet the statutory requirement and by implication to have “inadequate reserves”, whereas a scheme that is less conservative and/or holds an inadequate IBNR liability may appear to actually meet the statutory requirement and by implication to have “adequate reserves”.

Without professional guidance, there has been an absence of a standard methodology that is acceptable that schemes can use. It is therefore not possible to gauge the computation and to compare between schemes.

ASSA and SAICA have collaborated to draft this professional guidance. This first draft does not appear to provide a standard methodology, but has listed factors that need to be considered in the computation of the estimate. It is envisaged that once approved, this professional guidance will be endorsed by the Registrar of Medical Schemes. The effect of this endorsement is that medical schemes will have to comply with the professional guidance or justify any departure there from.

Registrar's view

While the professional guidance should provide a sufficient first step for medical schemes to adopt and should improve the robustness of the calculation, it may still be desirable to develop a formula for the calculation of IBNR. In those instances where schemes have departed from this formula, such departure should be disclosed in the annual financial statements and an explanation should be provided.

Comment focus

- The approach adopted in the development of the professional guidance.
- The required and actual contents of the professional guidance document, to include:
 - Discussion, by way of examples, of useful methodologies of calculating IBNR and the usefulness of including such examples in the guide.
- Comment on the possible formula.

5.4 Inappropriate asset structure

The issue

Medical schemes face liabilities (primarily claims) that are of a short-term nature. This needs to be considered when the scheme funds are invested. For instance, a medical savings plan is such a short-term liability that it is considered imprudent to invest such funds in equities, because of the risk profile of this asset class. This rationale extends to the general risk pool funds as already pointed out. Medical

schemes therefore always have to consider the balance between the need for capital preservation and the (usually seductive) need for obtaining high investment returns.

Taking into account this short-term nature of medical scheme claims, in general, a medical scheme should rather invest in a manner that limits risk exposure, with emphasis on liquidity by adopting a more conservative approach than a long-term vehicle such as a pension fund would, for instance. To do otherwise may put the scheme at risk that it may not be in a position to pay claims when they become due and payable. Granted, the more reserves the scheme holds, especially those in excess of statutory requirements and being held on a long-term basis, the more an argument can be made for investing in instruments such as equities that are more risky yet offering higher rates of return in the long run.

The statutory reserve requirement does not distinguish between schemes according to the structure of the investments. A scheme that has invested aggressively in risky instruments is not distinguished and accordingly is not required to hold more reserves compared to a scheme that has invested more conservatively.

Regulation 30 and Annexure B restricts the manner in which medical schemes can invest funds. The 2002 Regulations amendments have tightened up in this regard, and it is considered that this will reduce the level of inappropriate and aggressive investments in risky instruments. Stakeholder opinion on the appropriate structure of Annexure B was canvassed and obtained during the regulatory changes process of 2002.

It has been suggested that the requirement to have investment committees should be legislated, just like audit committees. This is the practice in the life insurance environment.

It has also been suggested that the asset admissibility concept would be a dynamic and better way of regulating medical scheme investments. In terms of this approach, assets would only be partially admissible towards the calculation of the required minimum reserves. The percentages admitted would vary according to the asset class. The more risky the asset class, the lower the percentage that would be accepted towards the

calculation of the minimum required reserves and vice versa. (For example, cash – 100%, bonds – 80%, equities –30%; property – 20%). The adoption of this concept would constitute a significant shift from the manner in which the minimum reserve requirement is calculated presently. The percentages that each asset class will qualify at will have first to be determined, and it is not clear how this will be done at this stage.

Registrar's view

The amendments to Regulation 30 and Annexure B of 2002 were widely canvassed and very useful input was obtained from stakeholders.

The introduction of investment committees by schemes is good practice and is already recommended in the trustee training that the Registrar's office conducts nationally.

The introduction of the admissibility concept sounds plausible in theory. However, it is not possible to introduce the concept unless the concept is sufficiently canvassed amongst the stakeholders and there is general acceptance of the idea. Further it would be necessary for a study to be undertaken to determine the relevant percentages to be used before consideration can be given to the introduction of this concept.

Comment focus

- The appropriateness, structure and content of legislating the requirement of establishing investment committees.
- The appropriateness of the admissibility concept. The appropriate manner of establishing the “allowed percentages” for different asset classes.

5.4 Unrealistic reporting requirements

The issue

In terms of Regulation 29 (4) any medical scheme that fails to maintain statutory solvency requirements for a prescribed period is required to report to the Registrar this fact along with reasons and details of a plan to meet this requirement. This prescribed period was 30 days.

Research has shown that, when looked at on a 30 day basis, medical scheme solvency can dip in and out of the required level during the year, and yet meet the requirement at the end of the year. This is attributable to the fact that schemes rely on investment income to meet the solvency requirement, and investment income is characterised by periodicity. Another factor that adds to this phenomenon is the seasonality of claims. In recognition of this fact, Regulation 29 (4) was amended in 2002 to impose these reporting requirements if a period of 90 days of non-compliance is maintained. This requirement is in line with the new requirement for quarterly returns introduced in the 2002.

Registrar's view:

This matter has been adequately addressed through the Regulation amendments.

The introduction of the quarterly returns in 2002 was significant in this regard. The Registrar's office will essentially be in a position to determine schemes' solvency positions at quarterly intervals. The office is currently investigating the proposition that any scheme that does not meet the solvency requirement should be prompted by the quarterly return programme to provide information, the nature of which would be in line with Regulation 29 (4), on how the scheme plans to address this non-compliance.

Comment focus

- The appropriateness of and the manner in which the quarterly return can be used to prompt non-compliant schemes to provide the information required by Regulation 29 (4)
- In general on the issue.

5.6 Claims experience and total expenditure

The issue

The current manner of calculating the solvency requirement ignores the level of claims and total expenditure. If a medical scheme incurs an underwriting deficit, the requirement to calculate required solvency on the basis of the (inadequate)

contribution seems inappropriate. The problem of inadequate contribution discussed above is relevant here.

This issue is also closely related to the question of the amount of scheme funds spent on non-healthcare expenditure. It has been the Registrar's concern for a while that the proportion of every Rand that is expended on non-healthcare expenditure is increasing.

It has been suggested that the solvency requirement should take into account total claims and/or expenditure. Essentially, the requirement would be rephrased such that the required solvency level is calculated on the greater of total contributions or total claims or expenditure. The calculation of total expenditure brings with it complications such as how to treat investment gains and losses for instance. This will have to be assessed against the simplicity of the calculation based on gross contribution.

The effect of this requirement would be to adjust upwards the required solvency level early, immediately a scheme incurs underwriting losses. This will push the scheme trustees to address the deficit early before scheme reserves are depleted to unacceptable levels.

Registrar's view

The simplicity of the calculation based on gross contribution is important. The complications associated with some items when determining total expenditure make this approach challenging. Stakeholder comment would have to be taken into account.

Comment focus

- The appropriateness of introducing the total claims and expenditure to the calculation.
- How the complications identified would be dealt with.

5.7 Savings account contribution

The issue

Regulation 29 (3) reads as follows “*A medical scheme must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than.....*” Essentially this means that in calculating the minimum reserves to be maintained, the denominator must include not only risk contributions, but savings contributions as well. The savings balance held is not included (as a reserve) in the numerator.

It has been argued that the current approach is overly conservative and creates a disincentive for schemes to offer savings accounts. Savings accounts are distinguishable from risk pools in that savings accounts do not carry the same risk as the risk pool. This is because a member’s benefits are limited to the amount contributed to a savings account. The risks that a scheme faces in so far as the savings accounts are concerned are limited to the following:

- *Bad Debts.* This relates to the risk of bad debts on savings advances. It is argued that only a few schemes face this risk and the risk reduces as the year progresses anyway. This risk should be addressed through appropriate provisions for bad debts in the income statement.
- *Investment risk.* This relates to the risk of savings balances being held in equities that experience a reduction in value. It is argued that this risk should be more appropriately addressed through a restriction of savings balances to cash or through a reduced reserve requirement more commensurate with this risk.
- *Fraud and Mismanagement.* The risk that the scheme will incur financial losses through fraud or mismanagement of the savings accounts does not warrant the current approach. It is argued that this risk is better addressed through appropriate service level agreements with administrators, with penalty clauses for losses incurred for instance.

The exclusionist view then argues that the statutory reserve requirements should be calculated on the basis of risk contributions only. This would have the effect of reducing the amount of reserves required to be held by a medical scheme

The Registrar's view

The arguments enunciated above have merit. However, these should be viewed against the background of the current solvency approach.

It should be recalled that the basis for the current requirement stems from the Campaign Report of 1957¹. This report stated the following:

- The minimum solvency requirement should be an alarm bell mechanism to warn against possible future failure.
- It should indicate the need for further investigations rather than providing absolute information as to the solvency position of the organisation.
- Recommended the use of 25% of gross contributions to test solvency

This shows that the 25% level should not be viewed as a pass level. Schemes that meet this requirement are still at risk of significant reversal of their financial fortunes resulting in failure within a short period of time. Indeed, the Registrar's office has seen a number of cases where schemes have experienced horrendous losses within a period of one year, resulting in these schemes being on the brink of folding. Accordingly, the 25% is only a minimum protection. Were savings accounts to be removed, the percentage required would likely be increased to say, 33%.

Another point to consider is that the industry has not reached a stage where it can be said that all the risk components faced by the scheme are clearly understood. Isolating one risk factor and excising it from the requirement is considered imprudent. It is rather better to wait until such understanding exists, perhaps through a study, and therefore all risks are addressed in the solvency requirements in an appropriate manner.

The Risk Based Capital approach is currently touted as a possible way of comprehensively identifying risks elements and addressing them more appropriately. The problem with this approach as it stands, is that it was developed in a foreign environment (USA) for organisations that are significantly different from our medical schemes. These organisations are called health management organisations (HMO).

¹ Cooper: Solvency and Medical Schemes in South Africa, 2001

Further, many trustees of medical schemes have indicated displeasure with the apparent complicated nature of the calculation. A lot of work needs to be done to tailor the approach for the South African environment. Once that has been done, a case for the adoption of the RBC approach in South Africa will have to be made and an assessment made of its appropriateness against the current approach.

The Registrar's office has maintained the position that the solvency calculation will be based on the gross contributions (that include savings contributions).

Comment focus

The issue in general

5.8 Risk transfer not taken into account – reinsurance

The issue

It has been argued that a reinsurance contract transfers some risk from the medical scheme to the re-insurer and the current manner of calculating the solvency requirement, does not give credit for this amount of risk transfer. This, it has been argued, is inappropriate. It has been suggested that partial credit for reinsurance needs to be provided. This situation is usually contrasted with the insurance industry where such credit is given. It has further been pointed out that because re-insurers are required, in terms of the relevant insurance legislation, to hold statutory reserves, this results in double reserving which amounts to inefficient use of capital.

It has further been argued that because all reinsurance agreements that medical schemes enter into are now “approved” by the Registrar, the question of inappropriate reinsurance contract does not arise anymore.

There is a need for determining an appropriate manner and level of this credit to be given. It has been suggested that reinsurance premiums should be netted against gross contributions, when calculating required reserves. There is no agreement yet as to whether this is the most appropriate manner of giving credit. This method does not address how partial credit would be dealt with.

Giving credit for reinsurance arrangements would have the effect of reducing the quantum of the statutorily required minimum accumulated funds

Registrar's views

The argument for giving credit for reinsurance has merit only where there is appropriate risk transfer.

The results of a study conducted by the Registrar for Medical Schemes previously showed that there had been a lot of inappropriate reinsurance arrangements that schemes had entered into. These inappropriate contracts resulted in massive losses for schemes with minimal and in some cases no real risk transfer. Where there was transfer of risk, the price paid was often not commensurate with the amount of risk transferred. Schemes experienced unjustified significant financial losses as a result of these reinsurance agreements. In light of this history, it is necessary to exercise caution before giving such credit.

There will have to be a review of the effect of Section 20 (3) to (7) of the Medical Schemes Act on the levels of inappropriate reinsurance contracts within the industry. This section renders any reinsurance contracts null and void unless such contract, or amendment thereto, has been submitted to the Registrar, along with an independent evaluation on its need and the Registrar's objections, if any, have been addressed satisfactorily.

It is unlikely that credit would ever be given for reinsurance contracts between the scheme and its related parties. The risks associated with these related party transactions render it imprudent to do so. It should also be noted that the "allowable" reinsurance at present only covers any residual risk that reserves are not sufficient to cover claims in a given year.

Comment focus

- The issue in general
- The appropriateness and manner for giving either partial or full credit for reinsurance transactions.

- Comment should also concentrate on the effect that the period of the contract should have on the level of credit. (This refers to the fact that some contracts have an annual timeframe, whereas others are multi-year contracts.)

5.9 Risk transfer not taken into account – managed care

The issue

A scheme can enter into managed care agreements that result in sharing or transfer of risk, such as capitation agreements. Similar to reinsurance contracts, it has been argued that where a scheme has entered into such a managed care agreement with risk transfer, credit on the solvency requirements should accordingly be given.

The first step towards managed care supervision started with the introduction of the accreditation process. This process is under way. However, there are no financial supervision requirements yet. These organisations are not required to hold statutory reserves.

Registrar's view

In view of the lack of financial supervision of managed care organisations, and with the primary risk remaining with the medical scheme, it is considered inappropriate to give credit for managed care arrangements.

Comment focus

- Issue in general
- Manner of determining credit for managed care arrangements, where appropriate.

5.10 Scheme specific risk not taken into account

The issue

The current manner of calculating required reserves has been criticised for being a broad brush approach. Schemes face different levels of risks depending on the several circumstances that each scheme faces. For instance, the level of risk will differ depending on the following factors:

- Open versus restricted membership schemes
- Size of scheme

- Demographic profile
- Growth plans
- Business plans
- Management expertise
- Board of Trustees expertise
- Ownership of own facilities
- Etc

It has been argued that there needs to be a more appropriate measure for calculating a scheme's solvency requirement. Such appropriate measure would take into account the level of risk facing a scheme and set the requirement at a level appropriate for that scheme taking into account the risk that the scheme faces.

The Risk Based Capital (RBC) approach has been suggested as the correct way to go in this regard. The RBC approach was developed for HMO's in a foreign environment (USA) that is vastly different from South Africa. These organisations are different from South African medical schemes, and their regulatory environment has progressed significantly compared to the local one.

Trustees have indicated their reluctance for the adoption of this approach because they found the manner in which the calculation is done very complicated. The feeling was that it would dis-empower the trustees if they are unable to understand how the calculation is derived.

ASSA have volunteered to conduct research on RBC for the South African environment. This research is currently under way. It is expected that results of this research will be available by the end of 2003. The research results will form the basis for the review of whether the approach can be adopted in South Africa.

The Registrar's view:

The RBC approach is a useful guide for identifying risk elements that medical schemes face and can be very useful as a framework. However, the RBC approach utilises factors that have not been tailored for South African conditions.

It is necessary for a study of the RBC approach to be undertaken. The purpose should be to tailor the approach for South African conditions. The study will have to identify risk elements that local medical schemes face and determine the factors in a manner that will be plausible. Until this study has been finalised, it is not appropriate to adopt the RBC approach.

Comment focus

- The appropriateness of the RBC approach
- Any experience in use of this approach
- The nature of issues to focus on in any investigation of the feasibility of the RBC approach for South Africa.

5.11 Regulatory action - the RBC way

The issue:

Regulation 29 (4) places the onus on medical schemes to report to the Registrar when the required level of reserves has not been met. Legislation gives wide powers to the Registrar and the Council for Medical Schemes to take action that is considered necessary when this situation arises.

In contrast, the RBC approach gives trigger points and provides a more specific guideline on the regulatory action that needs to be adopted. The following table illustrates the trigger points and Regulator and entity responses²:

RBC LEVEL	RESPONSE
Company Action Level (CAL = 200% ACL)	The entity must notify the Regulator of corrective actions it plans to take
Regulatory Action Level (RAL = 150% ACL)	The entity must submit or resubmit a corrective plan of action to remedy. After examining the entity, the Regulator will issue an order specifying corrective actions to be taken.

² Source: Research Report – RISK BASED CAPITAL REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS by *Milliman & Robertson Inc*

Authorised Control Level	The Regulator is authorised to take whatever regulatory action is necessary to protect the interests of policyholders, including taking control of the entity.
Mandatory Control Level (MCL = 70% ACL)	The Regulator is required to place the entity under regulatory control

There has been rare unanimity that this approach is preferable because of the certainty that it provides. The remaining question is, of course, what the different trigger points should be within the current solvency requirement framework. What level of solvency would attract mandatory control, for instance?

There have been further suggestions that there should be a required solvency level (currently 25%, and subject to the phase in provisions) and a recommended solvency level that would be in excess of the required level.

Registrar's view

The identification of trigger points with specified regulatory and/or entity actions at the different bands is appropriate. This approach can be adopted with the current system of calculating statutory reserve requirements.

Internal consultation is on-going within the Registrar's office and Council. Stakeholder comment will be of great interest.

Comment focus

- Trigger points within the current reserve requirement framework
- Suggested regulatory action
- The concept of required and recommended solvency levels

5.12 Self-supporting benefit options – Benefit design

The issue

The Act requires the Registrar not to register benefit options unless they are self-supporting in terms of membership and financial performance or unless they are

financially sound. The Registrar's office currently insists on each benefit option being self-supporting (*self-standing* in Afrikaans), and this has been translated to mean that any benefit option should not incur operational losses.

The main reason for this requirement can be traced to the policy of avoiding risk rating. The intention was to avoid schemes discriminating on any (unfair) basis except the member's income level and the number of beneficiaries.

It has been shown that a number of options are not viable when considered from a membership point of view. Trustees have been advised to close down such unviable options. On the other hand, some have argued that the determination of self-supporting should only have regard to the financial performance, and not membership. The argument is that as long as the benefit option is not incurring operational losses, the (low) membership should not be made an issue.

It has further been argued that by prohibiting option cross-subsidisation, the current approach goes against the very policy objectives of community rating and cross-subsidisation that the Act wants to uphold. Therefore the definition of self-supporting should be revisited. It has been suggested that risk pools / benefit options should be redefined. As a point of departure, prescribed minimum benefits and common benefits should be defined to consist of one risk pool (benefit option to use current parlance.) The self-supporting test would be applied at this level. Any additional benefits would be available at an additional price. This would represent a departure from the current paradigm.

Another challenge to the current paradigm has been the assertion that the closing down of loss making options results in adverse financial results for some schemes. Discontinuing loss making options often results in buy-down which, in fact, is more detrimental to the survival of the scheme in general and results in increased costs for especially low option members. It has been suggested that certain high options should be allowed to incur losses, because the members in fact contribute more than they would if they were to buy down.

Further, it has been argued that schemes that have significant reserves, above the statutory requirement, should in fact be allowed to incur operational losses at the level of some benefit options. This would allow the schemes to utilise the reserves to avoid significant contribution increases to members. After all, this is one of the reasons for accumulating reserves, that is, to limit future contribution increases. Members would benefit in this regard.

Registrar's view

There are on-going internal consultations and studies being done within the office on this question. It should be noted, however, that we would be loathe to revisit the definition of self-supporting options. Rather we would prefer to re-examine the basis for differentiation of options. Benefit options should not be created as a means of residual risk selection. Rather they should cater for income differentiation.

Comment focus

- The issue in general.
- Possible approaches to differentiation on the basis of income, with retention of the requirement for self-supporting options.