

**BOARD of
HEALTHCARE
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of SOUTHERN AFRICA**

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

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Board of Healthcare Funders of Southern Africa:

BHF's Comments on the Discussion Paper: 'Review of the factors that influence financial soundness of medical schemes'

1. Introduction

The Board of Healthcare Funders of Southern Africa (BHF) commends the Registrar and the Council for Medical Schemes for broaching the issues highlighted in the discussion paper with the Industry.

BHF welcomes the opportunity to comment on this paper under the following headings:

- General comments on the approach and issues under consideration;
- Comments relating to specific issues raised in the paper.

2. General Comments

BHF believes that the healthcare environment should be governed by appropriate regulation that addresses the deeper, long-term issues rather than the superficial, cursory issues that pervade this industry. BHF welcomes the consultative approach adopted by the Financial Soundness Forum in soliciting the views of the industry.

In addition to the issues raised in this discussion document, we believe that there are other issues which also need to be addressed in a similar fashion, particularly those relating to the impact of the Prescribed Minimum Benefits (PMB's) on scheme contributions (i.e., the upward pressure that the current regulatory framework is placing upon scheme expenditure).

We also share the Registrar's concern about non-healthcare expenditure and would welcome an empirically sound investigation into this area. *However, we*



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caution the Registrar that this matter goes far beyond the administrative costs of medical schemes. Examples of non-healthcare expenditure include practice costs and salaries of medical practitioners and their staff, their administrative costs, the accommodation and facilities costs, the salaries and administrative costs and all mark-ups and profits of private hospitals, the mark-ups and profits on all drugs, disposables and other items used in the provision of healthcare services. In the United Kingdom, where there is a proper costing system in the National Health Service, it has been found that non-healthcare expenditure forms between 80% and 90% of total costs. **The same is probably true of private sector healthcare in South Africa and it is high time that a proper analysis was performed.**

3. Specific Comments

We will assume the same numbering as that of the discussion paper for ease of reference

5. Issues pertaining to the calculation of the solvency requirement

5.1 Inadequate contribution setting and lack of statutory professional supervision

BHF agrees that professional guidance to the setting of contributions in the form of advice from the actuarial, accounting or other relevant profession could be useful to trustees. However it should be made clear that such professional persons cannot be held responsible for decisions made by the trustees on the basis of their advice. The nature of trusteeship is that the trustees have to apply their minds to all relevant issues, and that their plenary powers cannot be fettered. The onus of running the business of a medical scheme lies squarely with the Board, which must take all the necessary steps to ensure that this is properly done.

Professional advice on the setting of contributions would require that there be continuous monitoring of claims (which assumes rapid processing of claims) and that various factors (such as seasonal variations and possible changes in the



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scheme's demographic profile) be taken into account when contributions are adjusted. Contribution increases often take the form of "interim increases", imposed part way through the financial year. For these increases to be sensibly made, such prerequisites as rapid claims processing, rapid payment of claims and rapid production of management accounts have to be in place, together with the necessary governance structures within the scheme to make expeditious contribution adjustments. Furthermore, BHF needs to caution that a calculated increase in contributions does not necessarily lead to an increase in revenue or an improvement of the financial situation of a scheme that is experiencing difficulties. Often, such increases lead to the "good risks" leaving the scheme while the "bad risks" remain. In such instances, an interim increase could lead to a decrease in revenue while the levels of claims remain the same. This underlies the fact that contribution setting is not a scientific discipline and that political consideration, which are beyond the scope of the professions whose guidance might be sought, could be the most important single issue.

In the light of the above, while BHF supports the view of the Registrar that a professional guidance note from ASSA and SAICA on pricing of scheme contributions could be of assistance to schemes, such a guide would have to be applied with caution.



5.2 Definition of Reserves

BHF supports the view that arrangements are made, in conjunction with the Registrar's office, for appropriate special forms of reserves to be considered for inclusion in the definition of accumulated funds.

5.3 Inadequate IBNR Liabilities

BHF supports the idea that the trustees of medical schemes should seek professional guidance in calculating such provisions. An accredited professional could give this or, alternatively, guidelines suitable for local conditions, and which accommodate various scheme situations could be developed.

BHF would caution, however, that supervision by an accredited professional would add to non-healthcare cost expenses of the scheme and in most cases, the advantage gained would not warrant the additional expense. Furthermore, the

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calculations for most schemes are fairly simple and routine, unless there have been dramatic changes within the scheme (in which case, professional assistance might also have little to offer). Investigations into how adequate guidelines and software could be developed on a cost efficient basis should be part of any investigation, into the desirability of developing such guidelines.

5.4 Inappropriate Asset Structure

BHF supports the view that medical scheme investment should be appropriate to the situation of the medical scheme. Monies held against short-term liabilities or potential liabilities should be conservatively invested. Long term investment of monies not required in the foreseeable future should be treated in a different way, and it would be irresponsible of trustees not to invest the bulk of such funds into equities.

BHF thus proposes that a strategy very different from the conservative short-term requirements, be adopted for schemes that have reserves well in excess of the required statutory level. Investment of such monies of schemes should be subject to less regulatory intervention. For example, a progressive sliding scale could be used, designating the proportion of investments to which Regulation 30 and Annexure B apply. This would be designed to protect the monies held against short-term liabilities and other funds, which could be required in the short term.

BHF supports the suggestion that specialist investment committees could advise the Scheme's Board of Trustees on investment matters. Again, it should be made clear that such committees cannot, in terms of the law of South African Trust, interfere with the fiduciary duties of the trustees, who must, after due consultation and application of their minds, make the final investment decisions. BHF believes that the current regulatory framework (together with the Law of South African Trust) is adequate, and that the requisite expertise is available within the investment industry.

Although the concept of admissibility of asset classes appears to be an innovative way of regulating the investments of medical schemes, BHF believes it not to be appropriate at this stage. Hence, BHF does not support this concept in the current environment, but might review this position in future.



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5.5 Unrealistic Reporting Requirements

BHF believes quarterly returns for the majority of medical schemes to be a costly and unnecessary exercise, exacerbated by the demand of the Registrar that these be electronically submitted to an often dysfunctional interactive website.

Furthermore, BHF would caution that the conventional Gaussian statistical computations used in the analyses are wholly inappropriate for distributions as skewed as medical scheme data.

In addition, the following points should be observed:

- a) The period of a single quarter may be insufficient to determine reasonable representative data;
- b) The quarterly-based data would contain distortions such as extra or fewer processing weeks (making a difference of up to 16%), as well as seasonal effects, which may necessitate adjustment;
- c) Quarterly reporting requirements add to the non-healthcare cost component of schemes, and in particular, to the fees charged by administrators for writing and transmitting such reports.

5.6 Claims Experience and Total Expenditure

BHF does not support the view that solvency calculations should be done on gross contributions.

BHF suggests that the solvency calculation be done on net contributions because of the assumed *raison d'être* of reserve requirements. In addition, there should be an exact statement of the purpose of these statutory Reserves and there should be justification of any statutory determination of the appropriate level in terms of evidence-based, scientific principles. *The experience of the Industry is that even with small groups (of no more than 200 members in some cases), and considerable volatility in claims, at no time would more than one month's*

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contributions be required for the scheme to be assured of meeting all its legal commitments.

Furthermore, where risk is transferred in terms of contractually agreed arrangements with administrators, managed care organisations or other organisations, there is no need to hold reserves since there is no contingent liability that could arise.

Allowance, in any determination of statutory reserve levels applicable to a scheme, should be made for the situation where the scheme's costs are not covered by its contributions. Here, the obvious solution would be that the calculation of the required reserves should be on the basis of the greater of the contributions and the gross expenditure.

There is also the question of whether (and how) net investment proceeds should be taken into account. Here, simplicity of the calculation of statutory reserve requirements has to be balanced against the complexity of taking into account the many different forms of investment that schemes might utilise. In any event BHF would support the development a new method of determining the statutory reserve requirements, using evidence-based, scientific methodology.

The issue of proliferating non-healthcare costs, which are implicit in all the proposals of the discussion paper, would need seriously to be considered and monitored.



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5.7 Savings Account Contributions

BHF does not support the proposal that schemes be required to hold reserves against medical savings accounts contributions. The current statutory requirement ignores the fact that there is no risk to the scheme arising from savings account expenditure, and therefore, it should not be taken into account in any determination of statutory reserve levels. The above comment assumes that the purpose of the statutory reserve is related to the risk experience of the scheme, a matter, which as previously remarked, requires clarification.

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Reference has been made to the Campagne Report of 1957. In the view of BHF, this report is *outdated, having been created in circumstances far removed from those pertaining in our industry today.* Furthermore, it does not provide solid, evidence-based scientific justification of the statutory solvency requirements in the diverse situations pertaining to South African medical schemes. BHF believes that the Campagne Report does not accommodate developments such as medical savings accounts into its considerations and, moreover, unlike the statutory requirements, takes reinsurance contracts into account in its recommendations.

BHF supports a reserve requirement calculation that has been developed for local conditions and is based on hard empirical evidence, using scientific methodology. The current approach is biased against schemes offering savings accounts. BHF recommends that savings accounts contributions be excluded from any solvency calculation. If the Regulator requires higher absolute levels of reserves for any reason, his requirements should be justified using scientific, evidenced based methodology, instead of including inappropriate non-risk items (which require careful and consistent identification and treatment) to boost the totals.

BHF's views on Risk Based Capitation models will be given in section 5.10.



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5.8 Risk Transfer not taken into Account - Reinsurance

BHF notes that the current determination of statutory reserve levels takes no account of the risk transfer occasioned by the reinsurance arrangements of medical schemes. BHF supports the view that appropriate reinsurance, properly priced, is a useful risk management tool, which should be encouraged by the Registrar, and taken into account in reserve level calculations. In addition, such contracts also protect the scheme in the unlikely event of catastrophic claims fluctuations, thus reducing the need for sudden substantial contribution increases.

BHF thus supports a liberalising of the official attitude toward reinsurance contracts. Once the Registrar has approved such a contract, he should be willing to consider a motivation from the medical scheme concerned, to reduce the reserves required of the medical scheme, reflecting the risk transfer.

In essence then BHF would support the view of a 'credit' for reinsurance if:

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- a) There were an appropriate risk transfer;
- b) It could be demonstrated that the scheme involved would move towards enhancing its reserve levels by the end of the contract period.

This would probably exclude consideration of single year contracts, but longer-term contracts could be evaluated for this purpose.

5.9 Risk Transfer not taken into account – Managed Care

BHF believes that capitation agreements do reduce the risk to which medical schemes are exposed and that they should be taken into consideration in the determination of the statutory reserve level

Currently there are very little in terms of capitation agreements. The obstacles cited was that there were insufficient numbers because of the initial reservation, by providers, as to whom cushions the risk. In addition there was uncertainty around some of the intentions of regarding ACT 90, 1997 as to the GP dispensing provisions.

However, the accreditation and supervision process of managed care organisations that has begun needs to developed to a greater degree in order to accommodate the 'credit' consideration.



5.10 Scheme specific risk not taken into Account

BHF believes that reserves are essential for the continued financial soundness of medical schemes and supports the proposal that the determination of statutory solvency levels should be based on sound empirical research. As different schemes are exposed to very different levels of risk, the formula developed should be sufficiently flexible to enable each scheme to be considered on its own merits.

Some factors that could influence the risk of insolvency of a medical scheme are raised in the discussion paper. However, it fails to consider the cost of insisting

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that the presently specified statutory level of reserves be met within the currently determined time period. Schemes are currently limited in their ways of improving their reserves to cutting benefits or raising premiums only, and neither of these measures would necessarily be of benefit to the members of the schemes.

Addressing the factors listed in the report would alleviate some of the pressures facing schemes that are trying to build reserve capacity, but this needs to be done scientifically and effectively.

BHF notes the Risk Based Capital (RBC) proposals. International trends in aligning economic and statutory environments lend support to the view that the RBC approach is an effective method in this regard. BHF would caution that we need systems that are relevant to this environment

5.11 Regulatory Action – The RBC Way

BHF supports an investigation into the RBC proposals, but notes that there needs to be a sufficient amount of research done in order to ascertain trigger points appropriate for the local environment.

5.12 Self supporting Benefit Options – Benefit Design

BHF supports the philosophy that appropriately determined prescribed minimum benefits and open enrolment would eventually create a common risk pool, but cautions that the present statutory benefits are not appropriate for a common risk pool of all employed South Africans. BHF, however, believes that it should be possible to offer, within the medical scheme environment, additional benefits over and above this base, free from the current rigid regulatory environment.

BHF would raise the issue of major differences in income, which make it impossible to entertain all the expectations of the top income group within the same risk pool as the lowest income group. In addition, one of the most fundamental issues in a market economy is that of choice, and current proposals do not address this need.

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BHF notes that investigations are currently being conducted by the Registrar and trusts that their results will be made available for more detailed comment.

Conclusion

BHF believes that the continued financial soundness of medical schemes involves long-term (as well as short term) considerations, and that any reserve level beyond the equivalent of an average month's expenditure, is firmly placed within the realm of long term investments. To accommodate both short and long term considerations, as well as the differing requirements within the industry, there should be flexibility and that any regulation should be research-based, and founded on experiential evidence.

Finally, BHF would commend the Committee on the manner in which opinion has been canvassed and would welcome further discussion of the issues raised.

Please do not hesitate to contact this office should you have any query

Regards.



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Blamo Brookes

Chairman: BHF Regulatory Policy Committee

Cc. Financial Soundness Forum



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