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THE USE AND ABUSE OF REINSURANCE IN MEDICAL SCHEMES

By HD McLeod, PG Slattery and AM van den Heever

ABSTRACT
An investigation by the regulatory authorities into the use of reinsurance by medical schemes indicated clear problems with reinsurance agreements and cases where the contracts were resulting in substantial losses for members of schemes. It was shown that in a number of cases reinsurance had become a conduit for systematically removing surplus from medical schemes, thus undermining the security of members of those schemes. This paper summarises the key features of the investigation into the use of reinsurance by medical schemes over the period 1996 to 1999. The paper then outlines the actions taken by the regulatory authorities. The specific areas of abuse are described and the conduct of trustees, brokers, administrators and insurance companies is discussed. This leads to the question of the professional responsibilities of actuaries in the design and implementation of these arrangements.

KEYWORDS
Medical schemes; reinsurance; regulation; professionalism; trustee responsibility

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1. INTRODUCTION

1.1 An investigation into the use of reinsurance by medical schemes was initiated by the regulatory authorities in December 1999. The report presented to the Council for Medical Schemes in May 2000 indicated clear problems with reinsurance agreements and cases where the contracts were resulting in substantial losses for members of schemes. It was shown that in a number of cases reinsurance had become a conduit for systematically removing surplus from medical schemes, thus undermining the security of members of those schemes.

1.2 It should be noted that a medical scheme is legally a not-for-profit entity, managed on behalf of the members by a Board of Trustees. The scheme may contract with companies operating on a for-profit basis to provide administration, managed care, investment and other services to the scheme. In operation, a medical scheme is similar to a retirement fund.

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1.3 This paper summarises the key features of the investigation into the use of reinsurance by medical schemes over the period 1996 to 1999. The authors assisted in the analysis and have updated the results in Sections 3, 4 and 5 with data submitted after the first report. Specific areas of abuse are described in Sections 6 and 7. Section 8 outlines actions taken by the regulatory authorities and an overview of the proposed regulation.

1.4 The conduct of trustees, brokers, administrators, managed-care organisations and insurance companies is discussed in Section 9. Section 10 deals with industry criticism of the review and the counter-arguments that have been made. The concluding section deals with the question of the professional responsibilities of actuaries in the design and implementation of these arrangements.

1.5 This paper assumes a knowledge of the South African healthcare environment. Readers needing further background information are directed to the papers described in the references.

2. THE REVIEW OF MEDICAL SCHEME REINSURANCE: 1996 TO 1999

2.1 The implementation of the Medical Schemes Act, Act No. 131 of 1998, provided for the establishment of a new statutory regulatory authority, the Office of the Registrar of Medical Schemes. The enhanced capacity of the Office enabled progress to be made on a number of pressing issues.

2.2 The Council for Medical Schemes had expressed concerns over a number of years that reinsurance agreements were possibly being used to the detriment of medical schemes. An investigation into health insurance late in 1999 confirmed an increasing use of reinsurance and highlighted the mechanisms for the abuse of reinsurance.

2.3 Although the Act permits reinsurance (section 20(2) of the Act), it was never the intention of the law to permit these arrangements to be used to the disadvantage of scheme solvency and of the members of medical schemes. The regulations contained no restrictions on the nature of reinsurance arrangements, and it became clear that this loophole was being increasingly exploited.

2.4 As a consequence of growing concerns, the Department of Health, in conjunction with the Office of the Registrar of Medical Schemes and the Council for Medical Schemes, initiated a full review of reinsurance in December 1999.

2.5 The Registrar called for data from all schemes on the usage of reinsurance in the period 1996 to 1999. Schemes were required to submit:

- the names and affiliations of trustees and officers of the scheme during the period;
- the names of reinsurers used;
- the names of intermediaries and advisers used and the amount of brokerage paid;

– the minutes of all trustee meetings at which reinsurance was discussed;
– the contracts of reinsurance; and
– a standardised report on the financial impact of reinsurance on the scheme.

2.6 The review was aided by information supplied by the section 45(1) request sent to health insurers in December 1999. These insurance companies had been asked to supply information on any reinsurance contracts with medical schemes.

2.7 The brief for the reinsurance review required the Office of the Registrar to:
– review all submitted contracts;
– perform a quantitative evaluation of reinsurance contracts;
– make recommendations on appropriate reinsurance;
– make recommendations for action by Council and the Registrar; and
– assist in the development of regulations pertaining to reinsurance.
A number of schemes were tardy in submitting information. The results of the review were based on adequate information on the number and type of contracts but the amount spent on reinsurance arrangements was generally understated.

2.8 It should be noted that the only reinsurance contracts considered in this review were the primary contracts of reinsurance (i.e. those between a medical scheme and another party). None of the subsequent retrocessions (which may have involved a specialist reinsurer) were considered.

2.9 Note that community rating and open enrolment were introduced with effect from 1 January 2000. The use of reinsurance was investigated in the period 1996 to 1999, before the introduction of the new Medical Schemes Act.

3. THE PATTERNS OF USAGE OF REINSURANCE

3.1 GROWTH IN REINSURANCE FROM 1996 TO 1999

3.1.1 There was a significant increase in the number of reinsurance agreements with medical schemes in the period under review. The increase in reinsurance premium paid showed a dramatic and disproportionate increase, as shown in Table 1.

TABLE 1. Reinsurance in medical schemes from 1996 to 1999

	1996	1997	1998	1999
Number of schemes using reinsurance	13	20	30	56
Reinsurance premium paid (Rm)	32,1	246,6	1318,6	1714,7

3.1.2 This growth in use occurred during a period of mergers and consolidations in schemes. Open schemes were becoming fewer in number and larger in terms of average

size of membership. Additionally, the minimum number of members required to register a new scheme was increased during the period under review, thus the number of smaller schemes needing reinsurance should also have been in decline.

3.2 THE USE OF REINSURANCE BY TYPE OF SCHEME

3.2.1 The Medical Schemes Act allows for restricted-membership schemes that may limit membership to defined sponsor groups. The range of possible groups is described in the Act but in practice they are typically employment-based. Schemes not classified as restricted-membership schemes are considered to be open schemes.

3.2.2 The terminology in use under the new Act has been applied to schemes over the period 1996 to 1999. Colloquial terminology of the time included "closed schemes" for restricted-membership schemes and "commercial schemes" for open schemes.

3.2.3 At the beginning of 2000 there were 105 restricted-membership schemes and 50 open schemes in South Africa, according to the Registrar of Medical Schemes. At the time of the review, the Registrar's annual reports on the size of the industry were still several years out of date.

3.2.4 It is estimated that 23% of restricted-membership schemes made use of reinsurance in 1999, compared with 58% of open schemes.

3.2.5 Table 2 shows the usage of reinsurance by type of scheme in 1999. The surprising finding was that 99,5% of the reinsurance premium paid in 1999 was in respect of open schemes.

TABLE 2. Reinsurance by type of scheme in 1999

	Number	Reinsurance Premium (Rm)	Proportion by Number	Proportion by Premium
Restricted-membership schemes	24	9.3	45%	0,5%
Open schemes	29	1705,4	55%	99,5%
Status unsure	3	–		
Total using reinsurance	56	1714,7		

3.2.6 The growth of reinsurance premium over the period is almost entirely accounted for by open schemes. Reinsurance premium in restricted-membership schemes grew from R1,3m in 1996 to R9,3m in 1999; a factor of 7 times. Reinsurance premium in open schemes grew from R30,8m in 1996 to R1705,4m in 1999; a factor of 55 times.

3.3 THE USE OF REINSURANCE BY SIZE OF SCHEME

3.3.1 For this investigation, the definitions of size were:

- a small scheme has less than 6000 members, (i.e. it has less than the minimum number of members required for registration under the new regulations);
- a medium scheme does not meet the criteria for either small or large schemes; and
- a large scheme has more than 15 000 members or 30 000 beneficiaries.

3.3.2 It would be expected that small schemes would need to make more use of reinsurance than large schemes.

3.3.3 Table 3 shows that, as expected, most reinsurance in restricted-membership schemes was by small schemes. Only 5,5% of reinsurance premium was attributable to large restricted-membership schemes.

3.3.4 The surprising finding was that 95,7% of reinsurance by open schemes was entered into by large schemes, i.e. those with over 30 000 beneficiaries. Most reinsurance is therefore done by schemes that should have sufficient members to spread their risk internally.

TABLE 3. Reinsurance by size of scheme in 1999

	Small	Medium	Large	Incomplete data	Total
Restricted-membership schemes					
Number of schemes	8	2	3	11	24
Reinsurance premium (Rm)	6,6	2,2	0,5		9,3
Proportion of premium	71,0%	23,5%	5,5%		100%
Open schemes					
Number of schemes	6	4	13	6	29
Reinsurance premium (Rm)	8,5	65,5	1631,4		1705,4
Proportion of premium	0,5%	3,8%	95,7%		100%

4. THE NATURE OF REINSURANCE IN RESTRICTED-MEMBERSHIP SCHEMES

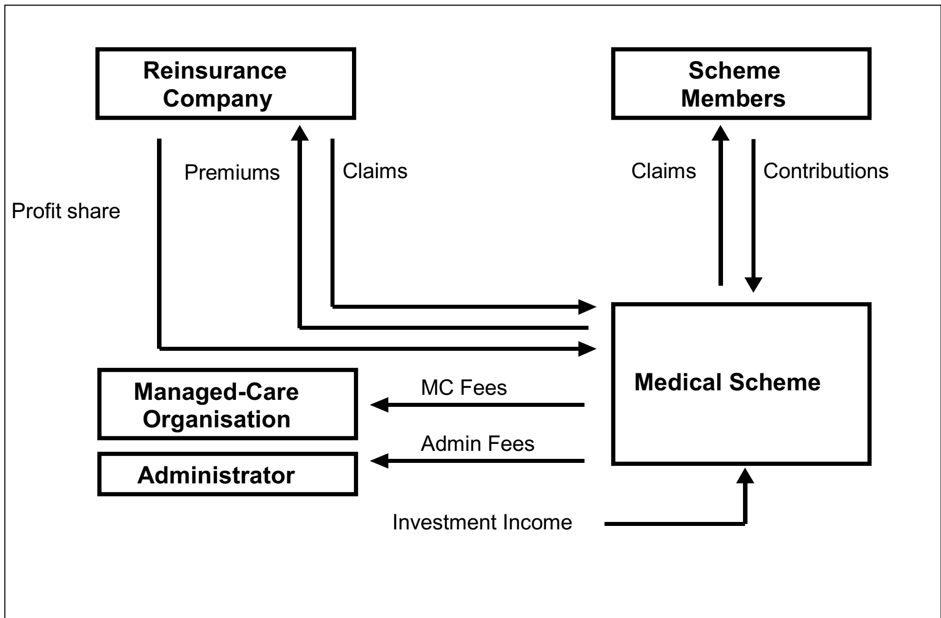
4.1 THE CONVENTIONAL USE OF REINSURANCE

4.1.1 Figure 1 illustrates the typical arrangement of parties in the medical scheme industry. A medical scheme contracts with an administrator and typically pays administration fees of a fixed amount per member per month. If a managed-care organisation is used, then managed-care fees may be paid on a similar basis. In some cases, the administrator and managed-care organisation are one legal entity. Note that all investment income accrues to the scheme.

4.1.2 Figure 1 also illustrates the model for the conventional use of reinsurance in medical schemes. The trustees of the scheme contract with a reinsurance company and any profit share is paid to the scheme.

4.1.3 Any registered insurer that is licensed for health business may also legally conduct health reinsurance. Specialist reinsurers dominate the business as they are best placed to provide pricing expertise and have a large client base to provide for the sharing of risk between schemes and different lines of business.

FIGURE 1. The conventional use of reinsurance



4.2 ORGANISATIONS PROVIDING REINSURANCE TO RESTRICTED-MEMBERSHIP SCHEMES

4.2.1 Restricted-membership schemes typically entered into conventional reinsurance contracts with the major specialist reinsurers. Of the 24 restricted-membership schemes that used reinsurance in 1999, 21 made use of specialist reinsurers.

4.2.2 One scheme made use of a complex cell captive arrangement, thus effectively controlling its own reinsurer. Onward reinsurance was entered into with another party.

4.2.3 Only one restricted-membership scheme is known to have entered into a reinsurance arrangement that allowed for the extraction of profit from the scheme as discussed in Section 6.

4.3 TYPES OF REINSURANCE CONTRACT IN RESTRICTED-MEMBERSHIP SCHEMES

4.3.1 The most common contract type was individual excess of loss. Only one aggregate excess-of-loss contract was reported and three schemes used stop-loss cover in combination with excess of loss.

4.3.2 USA regulators commissioned a study (Lewin Group, 1997) of the reinsurance arrangements of health carriers in that country. The report found a strong relationship between the size of the fund and the design of the excess-of-loss contracts.

Large funds had higher retention levels (also known as excess points) and the amount of the cover extended to higher cut-off levels (also known as upper limits).

4.3.3 The analysis of South African contracts for medical scheme reinsurance similarly showed that, for excess-of-loss contracts, the retention level increased with scheme size.

4.3.4 In some contracts retention levels were as low as R30 000 to R50 000. Also, in some contracts, cover was not provided above R200 000. (Illustrative claims distributions are shown in paragraph 7.3.2.)

4.4 IMPACT ON RESTRICTED-MEMBERSHIP MEDICAL SCHEMES

The total reinsurance premium paid over the period in respect of conventional reinsurance arrangements for restricted-membership schemes was R15,3m and the loss to schemes (i.e. reinsurance premiums paid less reinsurance recoveries) was R2,0m, giving a loss ratio (i.e. reinsurance recoveries expressed as a percentage of reinsurance premiums) of 87%.

5. THE USE OF REINSURANCE IN OPEN SCHEMES

5.1 ORGANISATIONS PROVIDING REINSURANCE TO OPEN SCHEMES

5.1.1 Table 4 below sets out three broad categories of organisations which provided primary reinsurance to medical schemes, the numbers of medical schemes reinsured with each and the reinsurance premium (for 1999).

TABLE 4. Organisations which provided reinsurance to open schemes in 1999

Organisation	Number of open schemes	Reinsurance premium
Specialist reinsurers	11	R11,9m
Independent insurers (or agents)	11	R38,0m
Organisations with a corporate relationship with the medical scheme or administrator	7	R1655,5m

5.1.2 A notable feature of the primary reinsurance of open schemes is that specialist reinsurers were not dominant. Of the 22 conventional reinsurance arrangements, only half were with specialist reinsurers. The counter-parties named in the other conventional arrangements included some unusual organisations (e.g. agents) and their legal ability to conduct reinsurance business will need to be clarified.

5.1.3 A surprising finding was that the conventional model of reinsurance accounted for only 3% of the premium paid by open schemes in 1999.

5.1.4 When measured by premium the business of removing profit from schemes dominated all other types of reinsurance. In the open schemes, funds were removed to another legal entity. Most cases were of open schemes transferring reserves to other

entities in the same group of companies. The use of reinsurance to extract profit is discussed more fully in Section 6.

5.1.5 The review also noted in a number of instances the use of a sole reinsurer, which typically reinsured all the risk business of the medical scheme. Here an insurance company would have only one client. Without a large number of clients, the risk-spreading opportunities are no different than those of the scheme itself. Typically these arrangements were in very large schemes.

5.2 TYPES OF REINSURANCE CONTRACT IN OPEN SCHEMES

5.2.1 Excess-of-loss reinsurance contracts were again the most common of the conventional arrangements. However, retention levels as low as R10 000 were seen. One very large scheme had a retention of only R20 000.

5.2.2 Two small open schemes appear to be legitimately reinsuring almost all their business in their start-up phase. A 100% quota-share arrangement was used in the first year of operation of a small scheme. This was one of the few examples of a legitimate proportional contract, i.e. where the contract was meeting a genuine need for risk transfer.

5.2.3 Where the extraction of profit was the goal, large proportional contracts (e.g. 80% or 100% quota-share arrangements) were fairly common. Such contracts enable a sizeable proportion of the medical scheme contributions to be transferred out of the scheme as reinsurance premiums.

5.3 IMPACT ON OPEN MEDICAL SCHEMES

5.3.1 The total known reinsurance premium paid over the period in respect of conventional reinsurance arrangements was R94,0m and the loss to schemes was R11,4m, giving a loss ratio of 88%.

5.3.2 The total known premium in respect of contracts with an organisation having a corporate relationship with the medical scheme or administrator was R3,2bn and the direct loss to schemes was at least R165m. The investment income lost by schemes as a result of reinsurance could have been of the order of a further R150m. The method adopted by one insurer meant a further loss to schemes of investment income of R77m. Thus the total loss to schemes from this form of reinsurance is estimated to have been of the order of R400m.

6. THE USE OF REINSURANCE TO EXTRACT PROFIT

6.1 One of the major reasons for the dramatic increase in reinsurance is that it has apparently become a means of extracting profit from non-profit medical schemes. This practice appears to have become common knowledge amongst insurers. A report by Warburg Dillon Read (WDR, 2000) openly describes the various reinsurance structures as methods for extracting profits from medical schemes. These arrangements can only occur where there is no arms-length arrangement between the medical scheme, the administration company and any of the other contracting parties.

6.2 "Although the administration company/health insurer would argue that reinsurance is necessary to secure and to manage the financial position of the scheme, *the potentially lucrative reinsurance commissions or retrospective profit shares also provide a strong incentive for reinsurance*. The scheme trustees are ultimately responsible for any decision to reinsure, *but in practice the administration company/health insurer is typically more closely involved than the trustees in the day-to-day affairs of the scheme and often has a strong vested commercial interest in how these affairs are conducted*. This may change as a result of the new legal requirements relating to trustees." (WDR, p.18). [Authors' emphasis].

6.3 The report by WDR describes two methods to extract profit from non-profit medical schemes using contracts of reinsurance. In the authors' view, both methods require the collusion of the medical scheme trustees with external contracting parties, or very weak trustees.

6.4 The first arrangement (Figure 2) occurs where a medical scheme takes out reinsurance with its administration company, which has an insurance licence. The administrator or insurer then reinsures with an outside reinsurer, which includes a profit-share arrangement. The administrator or insurer and the external reinsurance company often belong to the same group of companies. Here the administrator or insurer keeps all the interest earnings that would have been earned by the scheme on the reinsurance premiums.

6.5 For the administrators involved in such activity it was noted that a substantial proportion of their reported profit came about as a result of the reinsurance of a medical scheme.

6.6 The second arrangement (Figure 3) occurs in instances where the administrator has no insurance licence. Here the medical scheme contracts directly with a reinsurer, which has a special profit share arrangement with the administrator or managed-care organisation. The effect on the scheme is identical to that of the first type of arrangement.

7. FURTHER AREAS OF CONCERN IN REINSURANCE ARRANGEMENTS

7.1 THE ROLE OF TRUSTEES OF MEDICAL SCHEMES

7.1.1 A major concern emerging from the investigation is the actions of trustees of medical schemes.

7.1.2 Schemes were asked to supply minutes of meetings at which reinsurance matters were discussed. In many instances it appears as though no such records had been kept by the medical scheme.

7.1.3 In some cases the composition of the board of trustees of the medical scheme has been problematical, for example, key trustees sitting on the board of the insurer or broker involved in the transaction.

FIGURE 2. Extraction of profit – with an insurance licence (Model 1)

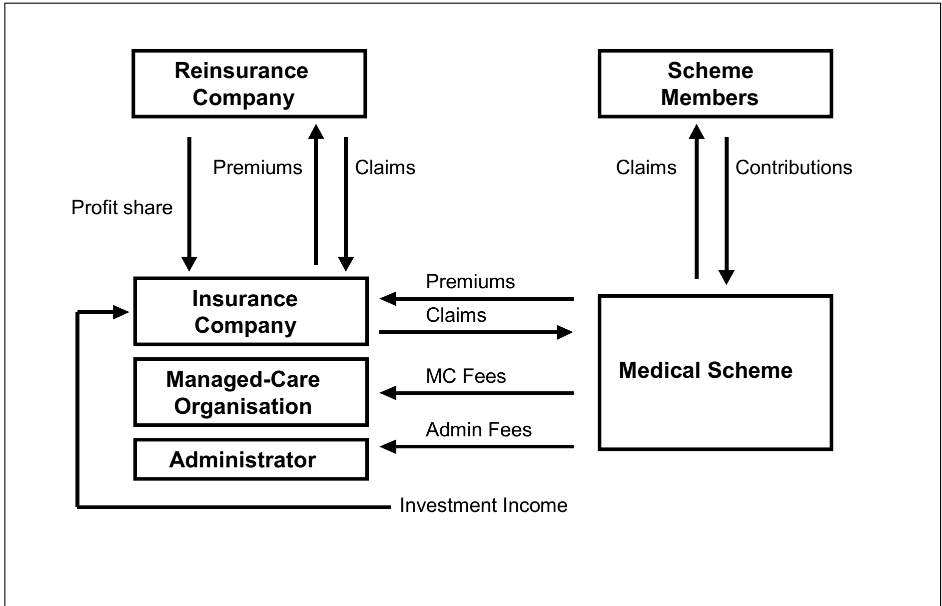
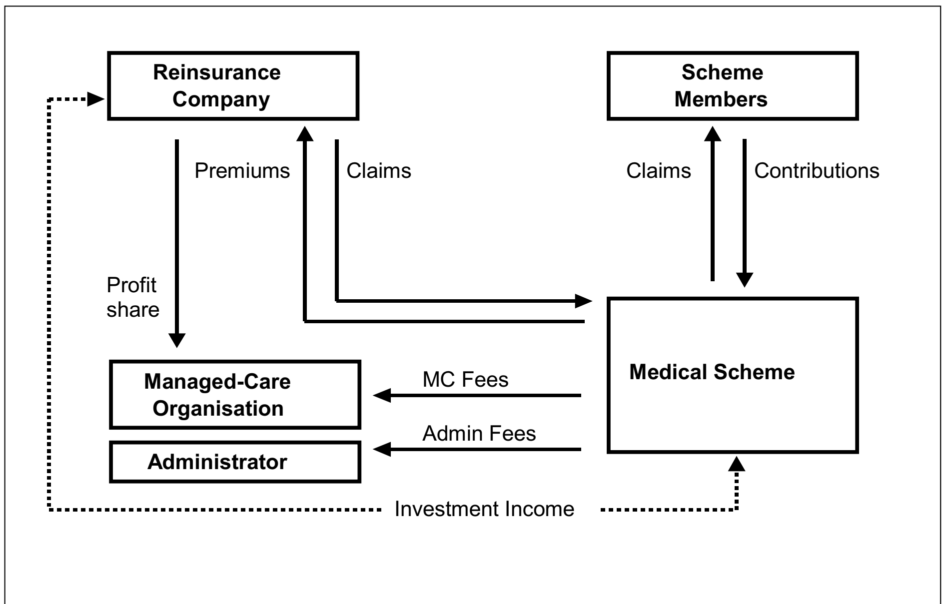


FIGURE 3. Extraction of profit – without an insurance licence (Model 2)



7.1.4 In the authors' view, the manner in which reinsurance has been implemented by medical scheme trustees has been unprofessional and may, in some cases, prove to be negligent.

7.1.5 The investigators were particularly concerned that the case for reinsurance was not seen to be questioned by any group of trustees. The minimum report trustees should have considered was a recent claims profile and details of the number of cases that would have fallen into the treaty parameters in the past. An assessment of the future risk should have been made and the effect of variability on financial results tested under a number of scenarios. Only once a case can be made for reinsurance, should trustees proceed to the stage of getting competitive quotations in the market.

7.1.6 In only a few cases did trustees consider quotations from a number of competing reinsurers.

7.1.7 There has been an over-reliance by trustees on brokers to recommend reinsurance contracts. In the light of information received on the excessive brokerage levels demanded, trustees should have regarded these unsubstantiated recommendations with much greater suspicion.

7.1.8 There has been an unquestioning acceptance of reinsuring via a company within the group and thus collusion to remove profits from the medical scheme for the benefit of shareholders of the insurer. In the worst cases, contracts were backdated to an earlier period. Thus risk premiums were being paid for periods after the claims results were apparent.

7.2 THE ROLE OF BROKERS

7.2.1 Several of the major specialist reinsurers expressed grave concern at the commission levels they have been forced to pay by certain leading broker houses. Bearing in mind that in the life insurance industry no brokerage is paid for reinsurance, it is extraordinary that commission levels for medical scheme reinsurance are of the order of 20 to 25% (and higher in some cases).

7.2.2 In some instances commission was paid to brokers who fell within the same group as the administrator and the reinsurer. There should have been no need for broker involvement in such cases.

7.2.3 Only 20 medical schemes reported the broker that had been used. The details about exact brokerage paid were seldom provided. One possibility is that trustees did not make it a concern to ask what brokerage was being paid, which if true would be a serious oversight. (In a substantial number of cases the reinsurance contracts did not even state the level of brokerage being paid.)

7.2.4 It is conservatively estimated from the reported figures that at least R7 million was paid as broker commission in the 1999 financial year. This money could have been more usefully used for healthcare expenditure.

7.2.5 The quality of the reports given by brokers to trustees does not appear to warrant the very high commission levels.

7.2.6 There are only five major specialist reinsurers. It seems unnecessary for trustees to call a broker when there are so few counter-parties with whom to do business.

7.3 INAPPROPRIATE REINSURANCE PROGRAMMES

7.3.1 The point at which a scheme no longer needs to reinsure because it has a large enough membership to withstand fluctuations in claims payments is not easy to determine. It will depend on the nature of the benefits and the scheme's demographic profile. Large schemes (with adequate solvency) should not need reinsurance, yet it was found that a number of very large schemes had entered into reinsurance contracts in recent years. Figures 4 and 5 below give the claims distributions, by number of claims and by value of claims respectively, for a typical large open medical scheme.

7.3.2 The upper level at which individual excess-of-loss cover was cut off was analysed. One of the major arguments for reinsurance used by marketing people is to cover unexpectedly large claims. Only one scheme had cover that was unlimited. Many of the smaller schemes had accepted cover that cut off at surprisingly low levels. One scheme had cover that ceased as low as R50 000. In general, the largest schemes had cover limits close to R1 million.

7.3.3 It would be expected that as a scheme grew, so its need for reinsurance would decline. In some cases the amount being paid in reinsurance premium was seen to increase as membership increased.

7.3.4 There has been an unquestioning acceptance of reinsurance via a company within the group of companies of the administrator or insurer and thus apparent collusion to remove profits from the medical scheme for the benefit of the shareholders of the administrator or insurer. In the worst cases, contracts were backdated to an earlier period, without any question by trustees.

FIGURE 4. Claims distribution by number of claims in a large open scheme

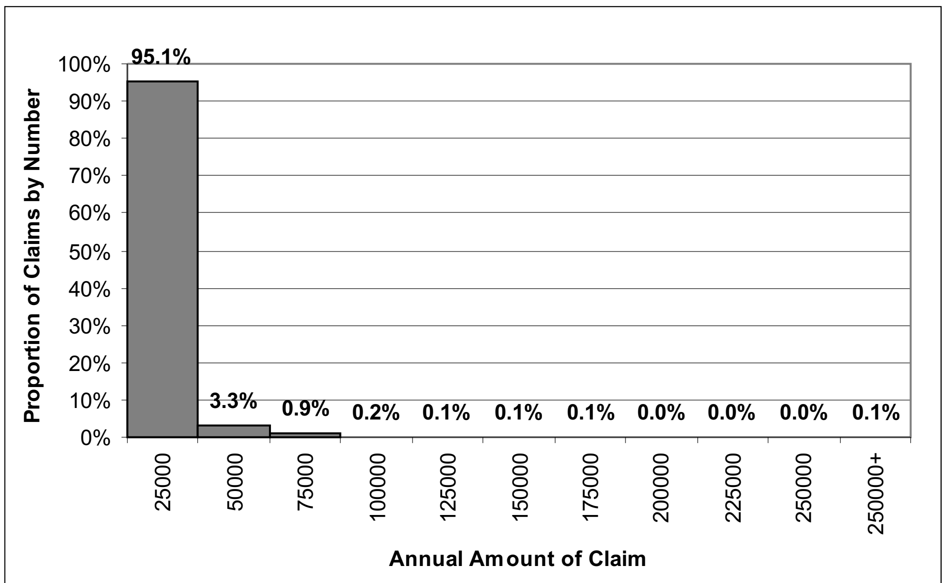
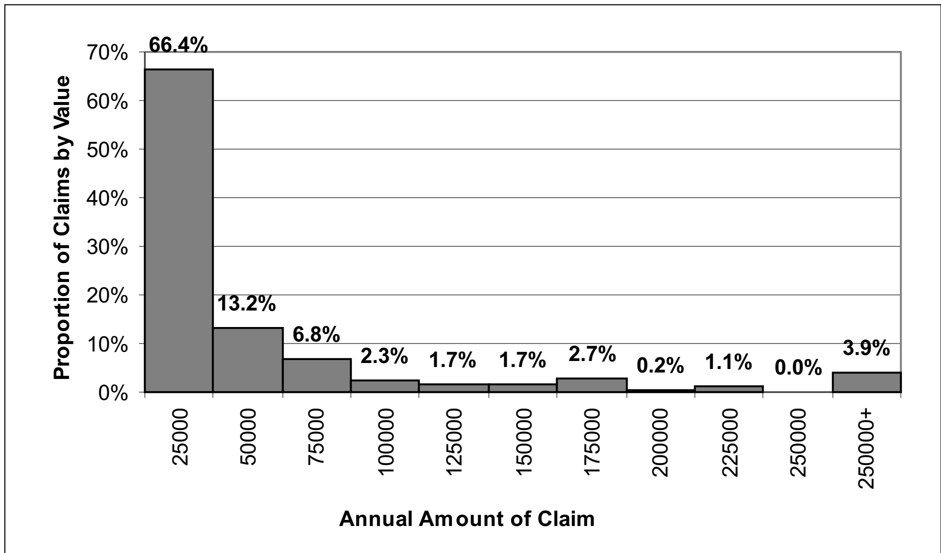


FIGURE 5. Claims distribution by value of claims in a large open scheme



7.3.5 A significant number of agreements involved the reinsuring of all the risks of the scheme and thus the payment to the reinsurer of all contribution income, resulting in substantial losses to the schemes.

7.3.6 In the majority of cases of reinsurance, no sound actuarial basis for the contracts could be found. In other words, these were not arms-length contracts entered into having regard to the risks faced by the medical scheme. In a number of instances there appeared to be little more purpose to the contracts than to transfer surplus out of the schemes.

7.3.7 Where schemes sustain systematic losses on their reinsurance agreements, their solvency position has been threatened. In such cases reinsurance was definitely not protecting scheme solvency.

7.3.8 The demarcation review by the Council for Medical Schemes found a number of insurers selling gap cover to medical schemes and calling it reinsurance. Gap cover provides payment for the difference between two tariff structures, e.g. between the lower Board of Healthcare Funders tariff and the higher South African Medical Association tariff. This falls within the definition of the business of a medical scheme and thus may not be sold as a contract of insurance or reinsurance. Gap-cover benefits were not always guaranteed in the medical scheme rules. Some insurers were clearly using the guise of reinsurance to provide gap cover, which is medical scheme business.

7.4 DOUBLE RESERVING

7.4.1 The reinsurer is required to accumulate a 30% solvency reserve in terms of the Insurance Act. This is in addition to the 25% solvency reserve required to be held by

the medical scheme in terms of the Medical Schemes Act. There is no offset for the medical scheme.

7.4.2 As a consequence, those schemes that had 100% reinsurance agreements had to adjust contributions to hold a solvency reserve of effectively 55%. At the very least the medical scheme would have to be compensating the reinsurer for tying up its capital to provide the required reserve. In some cases there was evidence of attempts to accumulate reserves within the reinsurer substantially in excess of the indicated percentages.

7.4.3 The problem for any medical scheme in an arrangement where reserves are being accumulated outside of the medical scheme, is that such reserves are permanently lost to the scheme when the reinsurance agreement is terminated.

7.5 THE LOSS OF FUNDS EARMARKED FOR HEALTHCARE EXPENDITURE

7.5.1 Over the four-year period less than 5% of reinsurance agreements examined improved the underwriting result of medical schemes. When the losses suffered by medical schemes as a result of the loss of investment income are taken into account, the position looks even worse.

7.5.2 The reinsurance losses ranged from 7% of accumulated reserves to over 100%, despite the fact that many of these schemes had reserves below the 25% minimum required. In certain instances schemes would have had adequate reserves if they did not take out reinsurance.

7.5.3 In many instances it is apparent that funds would have been put to better use had they been left with the medical scheme to meet healthcare expenses.

8. ACTIONS BY THE REGULATOR

8.1 ACTIONS APPROVED AND TAKEN

8.1.1 The Council for Medical Schemes met in May 2000 to consider the reports following the review of reinsurance and a number of actions were approved.

8.1.2 Fourteen schemes were identified as highly problematic and requiring further investigation. The Registrar met with the trustees of those schemes to discuss the concerns and the trustees were asked to determine the actions they planned to take to remedy the situation. It is possible that some cases may lead to formal investigations by the Registrar, as provided for in the Medical Schemes Act. Legal action will be instituted where appropriate. Schemes where there are other concerns about reinsurance and those where other financial problems have been identified, are being routinely followed up by the Office of the Registrar.

8.1.3 The Office was instructed to continue to monitor the situation and report to Council until the problems with reinsurance have been resolved.

8.1.4 The Office is to prepare a document outlining the process and information that trustees should use before entering into any reinsurance contract.

8.1.5 Proposed regulations on reinsurance were prepared for publication in the Government Gazette. The intention is to ensure that greater oversight of reinsurance contracts with medical schemes is provided by the Registrar.

8.2 THE PROPOSED REGULATION OF REINSURANCE

8.2.1 Definitions of reinsurance and insurers will be introduced into regulation:

– "reinsurance" in relation to the business of a medical scheme is a transaction in which an insurer agrees, for a premium, to indemnify a medical scheme against all or part of the loss that such medical scheme may sustain from carrying on the business of a medical scheme.
– "insurer" is a person regulated in terms of the Long- and Short-term Insurance Acts.

8.2.2 Regulation 6, dealing with reinsurance, will be added to Chapter 2, which deals with Administrative Requirements. In outline:

– A medical scheme will not be permitted to enter into any agreement of reinsurance that has not been approved by the Registrar. Approval must be obtained for any changes to an existing agreement.
– Where a reinsurance agreement is permitted, reports supplied to the Registrar must give details of each reinsurance contract, not in aggregate as in the past.
– The Registrar will have the power to approve a reinsurance contract only if:
  – there is a spreading of the risk of the scheme;
  – the agreement is in the members' interest;
  – there is no conflict of interest between the parties concerned; and
  – the scheme is exposed to identifiable risks of an unusual nature.

8.2.3 The proposed regulations will ensure that all contracts are reviewed by the regulator and thereby pre-empt the creation of inappropriate reinsurance arrangements. All contracts not explicitly approved by the regulator will consequently be illegal.

8.2.4 Agreements will not be permitted where there is no spreading of risk or where clear conflicts of interest exist between the board of trustees, the reinsurer, the administrator, and any brokers concerned. Actuaries and advisers to schemes will need to demonstrate that identifiable risks of an unusual nature exist and that it is in the members' interests to enter into the contract of reinsurance.

9. CONCERNS ABOUT THE CONDUCT OF MARKET PARTICIPANTS

9.1 THE CONDUCT OF BROKERS AND ADVISERS

9.1.1 In many instances brokers charged very high commissions (usually in excess of 20%). The quality of reports provided by brokers did not seem to warrant such high commission levels. Specialist reinsurers claim to have been "forced" by brokers to pay commissions at these high levels.

9.1.2 In some instances commission was paid to brokers who were part of the same financial services group as the administrator or the reinsurer. There should have been no need for broker involvement in such cases.

9.1.3 Much of the reinsurance was placed through a few dominant brokers.

9.2 THE CONDUCT OF SPECIALIST REINSURERS

9.2.1 Reinsurance contracts did not always specify the commission levels being paid, nor the broker involved.

9.2.2 Profit-sharing arrangements were often entered into between reinsurers and administrators. Although reinsurers would argue that this was important to create an incentive to the administrator, often all that this achieved was that it allowed the administrator to quote a seemingly low level of administration fee to a scheme, but in effect augment this fee through the profit-sharing arrangement. Any profit sharing should be with the medical scheme itself.

9.2.3 In many cases the reinsurer did not set the commission levels, but quoted a net price. Only when the contribution arrived from the client, did it see the size of the commission added to the net price. Reinsurers allowed this practice to develop and continue, to the detriment of their clients.

9.2.4 Although the specialist reinsurers had only a limited exposure to the primary reinsurance of open medical schemes, some were extensively involved in the onward reinsurance (retrocessions) by organisations that had entered into arrangements for the extraction of profit from medical schemes. In these instances there was generally a corporate connection with the reinsurer.

9.3 THE CONDUCT OF ADMINISTRATORS AND MANAGED CARE ORGANISATIONS

9.3.1 Opportunities for the extraction of profit from a medical scheme arise when the administrator has close links to the organisation providing the reinsurance, and where the administrator has great influence with the trustees of the medical scheme.

9.3.2 As mentioned in paragraph 9.2.2, some administrators entered into profit-sharing arrangements on reinsurance contracts as a way to augment the administration fees charged to medical schemes.

9.3.3 In some cases administrators took commission for putting reinsurance arrangements in place for client schemes.

9.3.4 In one case the management of the managed care organisation incentivised their staff with share options to encourage schemes to take large reinsurance contracts with an insurer within the same group.

9.3.5 One group of trustees stated that they had been “bullied” into accepting a contract of reinsurance by their managed care organisation.

9.3.6 In the annual report of one very large open medical scheme (with close links to a very large insurance company) it was reported to members that one of the reasons for reinsurance was “to establish a source from which commission could be paid for the introduction of new members.”

9.4 THE CONDUCT OF TRUSTEES OF MEDICAL SCHEMES

9.4.1 Ultimately it is the trustees of the medical scheme who are responsible for the decision to reinsure. Trustees were not adequately prepared to handle this responsibility.

9.4.2 Schemes were asked to supply minutes of meetings at which reinsurance matters were discussed. In many instances these minutes were not supplied, implying either that no proper discussion had taken place or that no such records had been kept.

9.4.3 There has been an over-reliance by trustees on brokers to recommend reinsurance contracts. In the light of information received on the excessive brokerage levels demanded, trustees should have regarded these unsubstantiated recommendations with much greater suspicion. Generally trustees did not seem to question the need for reinsurance, and usually did not get comparative quotations from the market.

9.4.4 There has been an unquestioning acceptance of reinsuring via a company within the group and thus collusion to remove profits from the medical scheme for the benefit of shareholders of the insurer. In the worst cases, contracts were backdated to an earlier period. Thus risk premiums were being paid for periods after the claims results were apparent.

9.4.5 Trustees were either colluding in the deliberate extraction of profit from medical schemes or were very weak in exercising their responsibilities.

9.4.6 In several instances trustees had serious conflicts of interest; for example, key trustees sitting on the board of the insurer or broker involved in the transaction.

9.5 THE CONDUCT OF INSURANCE COMPANIES

A number of insurers were selling gap cover to medical schemes and calling it reinsurance. Inappropriately large proportional contracts were often used in order to extract substantial amounts of a large open medical scheme's contribution income. Often the most blatant cases of profit extraction were associated with large insurance companies. Insurers and administrators seem to regard any open scheme they administer as their property, and were using the guise of reinsurance to extract what they regard as their surplus from the medical scheme.

9.6 THE CONDUCT OF ACTUARIES

9.6.1 It is an unpleasant but unavoidable fact that, in almost all instances, actuaries have been involved in the transactions in which reinsurance has been abused. Actuaries act as directors or senior management of the broker houses, insurance companies, administrators and managed care organisations or as consultants, and in some cases sit on the boards of trustees of medical schemes.

9.6.2 Where actuaries sat on the board of trustees of a medical scheme and simultaneously held senior positions in the organisation offering reinsurance to that scheme, it would appear as though there was a serious conflict of interest.

9.6.3 Designing arrangements aimed at systematically removing surplus from a medical scheme is contravening the spirit, if not the letter, of the legislation regarding the reinsurance of a medical scheme. Medical scheme surpluses belong to the members of the scheme.

10. RESPONSE TO CRITICISM AND COUNTER-ARGUMENTS

This review of reinsurance practices within medical schemes has drawn a sometimes heated response from industry participants. This section deals with specific points of criticism and responds to the more common counter-arguments made in defence of the arrangements observed.

10.1 NEED FOR EXAMPLES OF APPROPRIATE REINSURANCE AND SOUND ACTUARIAL ADVICE

10.1.1 There is substantial pressure from reinsurers to describe examples of appropriate reinsurance and to provide examples of sound actuarial advice. The authors contend that it is not possible to specify in advance particular categories, types or situations under which reinsurance will always be appropriate. It is always necessary for trustees to insist on a full appraisal of the risks faced by a particular scheme and an investigation into the possible financial consequences of those risks. While these investigations may not always be carried out by an actuary, the profession should have the expertise to provide assistance in this regard.

10.1.2 The Registrar called for trustees to submit full details of how they were advised and how they had reached decisions on reinsurance, including any reports considered. It is worrying to record that not a single report was submitted where the risks of the scheme were analysed or projections shown of how reinsurance would assist the scheme financially.

10.1.3 There is a need for the Actuarial Society of South Africa (ASSA) to assist members by providing professional guidance on the contents of reports on reinsurance proposals.

10.2 "REINSURANCE PREMIUM IS SMALL COMPARED TO TOTAL CONTRIBUTIONS"

10.2.1 Some schemes have attempted to demonstrate that reinsurance is not an important factor by showing reinsurance losses as a percentage of total contributions.

10.2.2 The size of reinsurance contributions is important in absolute terms, as a measure of additional expense to members. The more appropriate comparison is relative to administration costs and other non-healthcare expenditure. While the Registrar's reports have now been brought up to date, a full evaluation of historical non-healthcare expenditure is still in progress and hence these figures are not presented in this paper.

10.3 APPROPRIATENESS OF LOSS RATIOS

10.3.1 The loss ratios reported on in the review are provided for the record. The authors have not expressed an opinion on the size of the loss ratios in the industry.

10.3.2 In forums where the initial results were presented, reinsurers have at times insisted that they were making losses on this business. We thus present the loss ratios, as seen from the medical scheme perspective, as hard evidence in this discussion. The impact of the high levels of broker commission and the arrangements where profit was shared with parties other than the schemes, could well result in loss ratios greater than 100% from the perspective of the professional reinsurers.

10.3.3 Although the loss ratios are not necessarily unreasonable *per se*, the fact remains that they provide an indication of the level of losses that have occurred on contracts, which in many instances should not have been entered into in the first place.

10.4 "REINSURANCE CONTRACTS FACILITATE THE SPREADING OF RISK IN A PRUDENT MANNER"

10.4.1 It is argued by the industry that reinsurance provides a prudent method for a medical scheme to preserve its solvency and long-term stability. A reinsurance contract enables a medical scheme to transfer risk and to improve the management of its risk pool.

10.4.2 It is accepted that reinsurance can be used to improve or maintain the financial soundness of a medical scheme. It is not reinsurance *per se* that is questioned, but the use to which contracts have been put. Small schemes generally benefit from pooling risk with other schemes.

10.4.3 Note that agreements entered into by some large schemes did not pool risk with other schemes, but simply transferred risk to another entity in the same group. The circumstances of the particular scheme and the nature of the contract are important for assessing whether the use has been for a legitimate pooling of risk in an arms-length transaction.

10.5 "REINSURANCE CONTRACTS ENABLE MEDICAL SCHEMES TO RAISE CAPITAL EFFICIENTLY"

10.5.1 It is argued in some quarters that medical schemes require capital in order to provide their members with security in the event of claim fluctuations but are unable to obtain capital injections from third parties. Reinsurance is postulated as a way out of this dilemma. It is said that a reinsurance contract enables a medical scheme to pass certain risks on to a reinsurer where capital is resident, thus obviating the need for the medical scheme to raise capital by increasing contributions from its members.

10.5.2 The reason for requiring capital is an important consideration as the options faced by a medical scheme differ substantially according to the nature of the needed "capital". For instance, if the scheme is pricing aggressively to attract business and is using its reserves to do so, it will need to increase its contributions or decrease benefits at some future point. The situation could be temporarily delayed through the use of a reinsurance agreement, but within a fairly short period of time the increased contributions would be forced by the increased premiums required by the reinsurer. If the reinsurer did not increase the premiums it would make a predictable loss.

10.5.3 In those cases where schemes have significant membership, the solvency support should be adequately provided by the statutorily required reserve level of 25% of gross contributions. Statutory reserve levels do not differentiate on the basis of size of the scheme. Whereas the statutory reserves may not be sufficient to deal with claims fluctuations in some small schemes that are close to the required reserve level, the greater predictability of claims for large numbers of beneficiaries make it unlikely that a large scheme would be unable to cope with fluctuations if it maintains the required reserves.

10.5.4 Section 35(6) of the Medical Schemes Act prohibits schemes from directly or indirectly borrowing money without the prior approval of the Council for Medical Schemes. Where capital is raised using a reinsurance contract and without prior approval, it is done in contravention of the Act.

10.6 "REINSURANCE CONTRACTS SERVE TO ALIGN THE INCENTIVES OF A MEDICAL SCHEME AND THE INCENTIVES OF AN ADMINISTRATOR"

10.6.1 It is argued by some sections of the industry that administrators of medical schemes are paid a percentage of contribution income irrespective of the performance of the medical scheme. This form of remuneration creates a perverse incentive for an administrator to increase premiums since this will necessarily translate into higher revenue. It is postulated that a reinsurance arrangement within the same group creates an alignment of interests since the success of the administrator and insurer is dependent on the success of the medical scheme; i.e. the insurer has an incentive to manage claim costs efficiently since it will thereby be rewarded for the capital it has injected.

10.6.2 The practice of paying a percentage of contribution to the administrator is not common and would be considered in economic terms to be a defective form of contract. A rather elementary and transparent approach to aligning the interests of the two parties is to modify the contract of administration to include specific targets and deliverables. No reinsurance agreement is required to achieve this effect.

10.6.3 Significant problems may arise if a reinsurance agreement is used for such a purpose, particularly in very large schemes.

10.6.4 If the administrator is in control of the pricing of the scheme, as well as the reinsurance agreement, a structured loss for these schemes can be built into the agreement. Although the contribution pricing may prove incorrect, future contributions or benefits can be adjusted to increase the profits of the reinsurer.

10.6.5 An administrator with a profit-share arrangement with a reinsurer and scheme, where collusion exists, can achieve both year-on-year increases in contributions (increasing revenue through increases in the administration agreement) and a profit on the reinsurance agreement. As both administration and reinsurance agreements with medical schemes are annually re-priced, it is possible to set the annual contribution increase in such a way that a healthy reinsurance profit is achieved.

10.6.6 In the case of quota-share arrangements in large schemes, particularly at levels such as 100 and 80 percent, scheme funds are effectively being transferred into the control of another party. The funds could be used to provide capital for investment purposes to the administrator or other third parties. This contravenes section 35(8) of the Act where a medical scheme is prohibited from investing its assets or granting loans to a participating employer, any other medical scheme, any administrator, and any person associated with any of these parties. Once the funds reside in the bank account of the administrator, they can be used in contravention of section 35(8) without any scrutiny.

11. CONCLUDING REMARKS AND PROFESSIONAL DUTY

11.1 The review of medical scheme reinsurance showed that the amount of reinsurance used by medical schemes grew substantially over the period 1996 to 1999. Less than 5% of the amount, by premium, could be considered a legitimate use of reinsurance. Reinsurance has become a mechanism for the removal of profit from not-for-profit medical schemes, to the detriment of scheme members.

11.2 The conduct of all market participants is cause for concern. The unpalatable fact is that actuaries are to be found in positions of responsibility in the parties involved in the abuse of reinsurance of medical schemes, for example as medical scheme trustees or directors of organisations where serious conflicts of interest exist.

11.3 Presidents of the Faculty and Institute of Actuaries have commented on several occasions (for example Thornton & Low, 1999), in discussions on the vision and values of the profession, that actuaries need to have regard for the interests of policyholders and have concern for the public interest.

11.4 In a recent article (Truyens, 2000) the President of ASSA commented that "Included in the four thrusts of our strategic plan was the intention to raise ASSA's public profile and to increase the public's acceptance of the independence of actuaries." and "While we pride ourselves on our professionalism, we must realise that we will be increasingly challenged to satisfy the general public, and those personally affected by our advice, that our members are living up to our high standards."

11.5 Members of the profession who were also trustees have not been seen to be acting solely in the interests of members of medical schemes. This reflects on the profession and raises serious issues about the actuary's role in society.

11.6 The authors call on ASSA to develop a clear position on medical scheme reinsurance and prepare professional guidance for healthcare actuaries on the appropriate use of reinsurance in medical schemes.

11.7 The authors call on ASSA to prepare relevant professional guidance on requirements for any actuarial reports presented to medical scheme trustees and the Registrar of Medical Schemes.

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APPENDIX A
BACKGROUND INFORMATION ON THE SOUTH AFRICAN HEALTHCARE ENVIRONMENT

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