

## Using Captive Insurance to Finance Student Health Risks in Zimbabwe State Universities: A Concept Paper

*Masiyiwa, S., Makaza F. and Marufu A.  
Department of Insurance and Risk Management  
Midlands State University  
Gweru, Zimbabwe*

### **Abstract**

*Universities all over the world view medical insurance as a critical aspect that any caring institution needs to put in place upfront. State universities in Zimbabwe have traditionally financed student health risks using commercial medical insurance. Both the students and the institutions of higher learning have also traditionally relied on funding from the fiscus. The current liquidity crunch the economy is facing following the introduction of the multiple currency regime in February 2009 has adversely affected the capacity of the government to adequately support the institutions financially. The current financial support to students under the cadetship programme is inadequate to meet the tuition fees and living expenses. Currently student health risks are financed by commercial medical aid societies who charge \$30 per semester for their basic packages. Students must show proof that they have paid for their medical insurance before they can register for the semester. This fee, although modest, is increasing the burden of the students as salaries of most of their guardians who are formally employed have remained very low since the introduction of the multiple currency system. This paper discusses the limitations of medical aid societies as a student health risk financing mechanism in Zimbabwe state universities. It also alerts the state universities of the existence of alternative risk transfer (ART) solutions which they can adopt and implement for the benefit of their students.*

**Key Words:** Medical insurance, Captive Insurance, Alternative Risk Transfer.

### **Introduction**

Universities all over the world view medical insurance as a critical aspect that any caring institution needs to put in place upfront. State universities in Zimbabwe have traditionally financed student health risks using commercial medical insurance. Both the student and the institutions of higher learning have also traditionally relied on funding from the fiscus. The current liquidity crunch the economy is facing following the introduction of the multi-currency regime in February 2009 has adversely affected the capacity of the government to adequately

support the institutions financially. The support to students under the cadetship programme is inadequate to meet the tuition fees and living expenses as it is limited to a paltry \$300 per student per semester while the tuition fees in Zimbabwe state universities currently range from \$500 to \$800 per semester. These fees do not cover living expenses which average \$500 per semester. On average, students in state universities need a minimum of \$1200 in order to pay for tuition and living expenses.

In addition, students must furnish proof of current membership to a medical insurance scheme before they can register for the semester. Currently student health risks are financed by commercial medical aid societies who charge on average, \$30 per semester for their basic packages. The fee, although modest, is increasing the burden of the students as the income of most of their guardians who are formally and informally employed has remained very low since the introduction of the multiple currency system. This paper discusses the limitations of medical aid societies as a student health risk financing mechanism in Zimbabwe state universities. It also alerts the state universities of the existence of alternative risk transfer (ART) solutions which they can adopt and implement for the benefit of their students.

## **Background**

Healthcare finance and services providers in Zimbabwe were not spared by the decade long economic meltdown that affected the country between 1998 and 2008. In the second half of 2008, all medical aid societies practically collapsed and became irrelevant when co-payments demanded by service providers exceeded their global limits on benefit payments. This mismatch, saw many clients, the state universities included, canceling their membership to such schemes and retaining the risk themselves, either funded or unfunded.

According to the Insurance Council of Zimbabwe (2007), capital bases of insurers (medical aid societies included) were progressively eroded over the period. The final nail to their coffin came in February 2009 when Zimbabwe adopted the multiple currency system. The change over from the Zimbabwe dollar to a multiple currency system brought the much needed economic stability and sanity that had eluded the policy makers for years. However, according to Biyam (2010) the inflow of foreign currency in Zimbabwe has remained insignificant and the whole economy is now reeling under a liquidity crunch.

The capacity utilization by industry that had on average sunk to as low as below 10% has dramatically risen to over 50% as at 30 June 2011. However, economic activity remains largely subdued as most sectors are having challenges in securing lines of credit to finance their operations. The insurance sector rides on the success of industry and commerce and the challenges currently being faced by industry and commerce have a direct impact on the volumes of new insurance business generated.

This development has significantly reduced the inflow of contributions to medical aid societies, who although operating, are still to fully recover and offer full scale benefits to their members. For instance, members (students at state universities included) are still incurring huge shortfalls on their medical bills. As a result, the medical aid societies are increasing their subscriptions in order to remain afloat. For example, Premier Service Medical Aid Society (PSMAS), the largest medical aid society in Zimbabwe with an estimated membership of over 500000 has on two occasions increased subscriptions for their Select, Value and Excel packages since the introduction of the multiple currency system. According to PSMAS (2011), the review has been necessitated by both the increased cost of healthcare and the need to give members access to best, healthcare facilities in the country and beyond. The first increase of 100% was implemented with effect from 01 September 2010. A second increase of 80% was implemented with effect from 01 September 2011. This translates to over 180% increase when according to the Zimbabwe National Statistics Agency (2011), the year-on-year inflation was 4.3% in September 2011.

### *Recent developments*

Contributions made to medical aid societies are made on the understanding that if you do not use it you lose it. This is understandable as medical aid schemes are basically risk pooling and sharing solutions and premised on the principle that the misfortunes of a few should be met by fortunes of many. However, the tight liquidity situation in the economy is forcing many entities to adopt innovative risk management strategies as an alternative to purchasing commercial insurance (medical insurance included). The major objective is to retain as much cash as possible within the organisation and only outsource those risks that exceed their risk limits.

The economic challenges of the past decade that, Zimbabwe faced as a nation exposed the limitations of the insurance device as a risk financing tool. The

insurance device was battered by hyperinflation and rendered irrelevant. For example, lifetime savings through life assurance and pension schemes were eroded to less than US\$1.00 leaving the beneficiaries without savings when they needed them most. Some life offices have since redenominated the benefits into United States of America dollars. However, the benefits currently being paid, despite this humane and noble gesture have remained very low and average US\$10 per month for most pensioners.

The insurance consuming public has also learnt that insurance is not the solution but part of the solution and that there exist equally good and competitive alternatives to insurance. Some medium to large scale organizations have since created self administered insurance schemes (captives) to cater for a variety of risks they face in their operations, e.g. material damage, health, funeral, superannuation etc.

Bawcutt (1997) defines a captive as an insurance company established with the specific objective of financing risks emanating from their parent group or groups. The captive insurance concept is not new as it has been practiced in America since the 1950s. It evolved as the insurance markets hardened and premiums increased against the backdrop of declining market capacity. Most corporations, both large and small, have ever since resorted to the use of captives in financing multifarious risks they face on a daily basis. Roosenbloom (2005) argues that employee benefits today can be financed by equally good and competitive alternatives like captives. The authors argue that the concept can be extended to any organized groups, for example, students in Zimbabwe state universities.

Strider and Kwon (2007) note that the development of the concept has largely been influenced by the following factors:-

- Poor conventional insurance pricing models which base premium calculation on average risks. This approach effectively overprices good risks and results in the subsidization of bad risks.
- Possible insurer default risk. Despite the existence of stringent regulations, insurance contracts carry a default risk for the client. In Zimbabwe although, no insurer failed in the past decade, there was extensive use of the average condition on material damage insurance coverages. Invoking of the average condition restricted the insureds to receiving less than full indemnity in times of loss.
- Local market capacity constraints. The introduction of the multicurrency system in Zimbabwe in February 2009 has compounded existing capacity constraints of the insurance and reinsurance sector. According to the

Zimbabwe Insurance Survey (2007) capital bases of all insurance companies were eroded by hyperinflation. As a result, large organisations e.g. Air Zimbabwe, ZESA (electricity power utility), NRZ (railway services), mines, etc, are increasingly failing to get the insurance cover they need for their very expensive plant and machinery.

- Cash flow management. Premiums for insurance policies are payable a year in advance and this may strain the client financially, against the backdrop of the liquidity crunch in the economy.

In Zimbabwe, ZB Holdings together with other stakeholders have formed Cell Insurance Company (Pvt) Limited to underwrite their insurable risks. Cell Insurance Company (Pvt) Limited is spearheading the adoption of the concept in Zimbabwe through its "rent-a-cell" captive arrangement. It currently administers a lot of such schemes that provide material damage, health and funeral insurance coverages. The rent a cell captive arrangement allows a client to lease the capital of an existing captive insurer so that the insured can fund some of their risks efficiently (Skipper and Kwon, 2007).

Most students in Zimbabwe state universities are young adults who rarely use their currently medical insurance. In addition the cover they enjoy under the medical insurance basic packages has very low global limits and a host of exclusions. However, the concept is still the same: if you do not use it, you lose it! The level of contributions and global limits on benefits is under the control and discretion of medical aid societies.

According to the Deputy Minister of Health and Child Welfare, Douglas Mombeshora is quoted saying that Zimbabwe needs a lasting solution to the high tariffs demanded by health care providers. Recently, PSMAS, the largest medical aid society in Zimbabwe with an estimated membership of 500 000, wrote to its clients advising them of an increase in tariffs with effect from 01 September 2011 citing increased operational costs and the need to provide best healthcare to its in Zimbabwe and beyond. Despite this assertion members (especially those on the basic packages) continue to incur huge shortfalls on their medical bills. The level of contributions is not negotiable, and so are the global limits. The unscrupulous medical aid societies and some errant medical practitioners who are still to recover from the profiteering hangover of the Zimbabwe dollar era are literally, getting richer at the expense of the members, university students included. Retaining in-house the contributions state universities currently pay to various medical aid societies and health insurance could make a difference to the already burdened students and their guardians.

*Advantages of using captives*

According to Bawcutt (1997:162) the following benefits that accrue to the sponsoring organisation using a captive as an alternative to commercial insurance could also accrue to the students in state universities:

- Contributions to the fund should be lower as members will not pay for medical aid society or insurer's expenses and profit margin.
- Interest from the investments will accrue to the fund
- Any profits or operating surplus will accrue to the fund
- Benefits can be tailor made, improved and enhanced with time as the fund grows.
- There will be no disputes with medical aid society or insurers over claims settlement.
- There would be a very strong incentive by members to reduce claims and control losses because they own the fund and its assets.
- Global limits can be increased easily with minimal or no increase in contributions from the members.
- Improvement in students morale can be achieved thereby increasing academic performance.
- Concessional tariffs can be arranged with leading service providers, e.g. drug manufacturers, hospitals, doctors, opticians (Bayes, Keller and Valerius 2002).

*Disadvantages of using captives*

Strider and Kwon (1997:277) and Bawcutt (1997:163) further note that the use of captives is not without risk. Any organisation intending to finance its risks using alternative risk transfer strategies should be fully aware of following pitfalls:

- The claims statistics, which are used to decide on monthly contributions payable, will come from a narrow base and errors may be made with very serious financial implications to the fund. However, the authors recommend that the risk arising from errors in costing be reinsured on a stop loss basis with local reinsurers. Cover is not only readily available but is affordable at an often negotiated premium.
- A catastrophic loss (although remote) could occur in the formative years and wipe out the fund. However, catastrophe cover can be separately arranged with leading reinsurers for a very low premium to cover the fund against an accumulation of claims above the expected budget in any given accounting period.
- Individual small claims may not affect the fund too much but their aggregate effect may have catastrophic effects. Catastrophe cover, as described above can also be arranged to mitigate this risk.

- There will be need to employ additional staff to handle the fund's administrative matters. True, but use of existing medical clinics and facilities at state universities should reduce the number of additional staff required.
- There may be a temptation to "dip" into the fund and pay for unrelated activities. This must be resisted by the board of management/trustees. In any case the business of the fund should be separate from that of sponsoring universities. If the "dip" is to be allowed it should be a loan based on prevailing commercial bank loan terms and conditions.
- Benefits from the basic insurance principle of spreading risk will be lost.
- Technical advice from service providers is lost or available at a cost. The authors note that the state universities have on their payroll experts in various disciplines, e.g. lawyers, risk managers, actuarial scientists, finance personnel. They recommend that the proposed fund should utilise the internal expertise in order to contain costs and only outsource other specialist services on a needs basis.

From the foregoing, the authors conclude that the advantages far outweigh the disadvantages. The disadvantages, although real, are surmountable as there are various practical mitigatory mechanisms that can be adopted by the proposed medical benefit fund as argued above.

#### *Proposal for the state universities*

It is against the above background that the state universities should consider setting a self administered medical benefit fund to finance health risks students are exposed to on a daily basis. The medical benefit fund will be financed 100% by the students. Zimbabwe has nine state universities and as at December 2007 they had a cumulative enrollment of 44305 undergraduate students. From 2009, when universities reopened after their brief closure in 2008 at the peak of hyperinflation, enrollment figures have been steadily rising as state universities look for alternative sources to augment their limited financial support from the fiscus. Although there are no latest official enrollment figures it is estimated that there were 55000 undergraduate students in state universities as at December 2010. Costing of commercial health insurance schemes is based on the law of large numbers. According to Valismakis, Vivian and du Toit (2002) the larger the statistical base, the more reliable the estimate of the loss ratio and pricing becomes.

Some medical aid schemes operating in Zimbabwe today actually started as in-house schemes with even fewer numbers. For instance, both Fidelity Life Medical Aid Society (FLIMAS) and First Mutual Medical Savings Fund (FMMSF) who are

now household names in Zimbabwe started as contributory in-house medical schemes for employees each covering less than 400 members.

In terms of the Medical Services Act, Chapter 15:13 a medical benefit fund applying for new registration should have a minimum of 2000 prospective members. The estimated 55000 university students do not only exceed the statutory minimum requirements but also allow for more accurate costing of the proposed medical benefit fund. The initial determination of the levels of contributions and limits of benefits should be guided primarily by Commercial and Industrial Medical Aid Society (CIMAS) and Premier Service Medical Aid Society (PSMAS) basic packages scales in the absence of full data on current utilization figures from the state universities. These can be reviewed as the experience of the fund becomes available.

Currently each state university has a medical clinic on campus staffed by qualified nurses. Most of them have the support of a medical doctor who visits at least twice a week to attend to the more serious cases. The existing medical clinics are providing a very essential service to staff and students. They are partly funded by a small levy on students' fees. The authors assume that most of the administration work of the proposed medical benefit fund will be done by the state universities using existing structures. The objective will be to reduce and contain costs of administration for the proposed unified medical benefit fund. Based on the above assumptions, the level of contributions computed could be 50% of what members currently pay to the various schemes but for similar levels of benefits. However, the authors recommend that the current level of contributions be maintained and any surplus arising could be used to reduce member contributions in future or to finance better medical benefits in the long run.

### **Suggested Implementation Plan**

To expedite the process, a technical committee consisting of representatives from the state universities should be set up. The committee should consist of both management representatives (50%) and student representatives (50%). The objective of this composition is to ensure 'buy-in' at the early stages and also incorporate the various stakeholders' interests and ideas in the scheme and benefit design.

### **Drafting of the constitution**

The day to day business of the proposed medical benefit fund will be run according to its Rules and Regulations as enshrined in its Constitution. The technical



committee will be responsible for drafting the Constitution, Rules and Regulations, which will include, *inter alia*:

- The name and objects of the proposed medical benefit fund
- Board of management/trustees, appointment and composition, meetings, its powers and functions
- Membership issues e.g. eligibility, application, termination, deprivation of membership, etc
- Subscriptions e.g. level, frequency, mode of payment and review of subscriptions.
- Beneficiary ship e.g. eligibility, application and termination of beneficiary ship.
- Schedule of benefits e.g. nature and amounts of benefits, eligibility for benefits, waiting periods, claims for benefits, rejection of claims, ex-gratia payments.
- Assets, liabilities, rights and obligations of the medical fund
- Actuarial valuation if any
- Dissolution/winding-up of medical benefit fund
- Amendment of rules e.g. power, requirements for amending the rules
- General information for members e.g. benefit exclusions, lodging of members' complaints and requests, payments of awards not supported by receipts, payment of service providers, list of approved providers, letters of guarantees for services provided outside Zimbabwe, shortfalls, travel cover on holiday, business or study.
- Promotion of the medical fund for acceptance by target service providers and establishing working relationships with them

### **Benefit design**

The technical committee must design a health insurance plan with attractive features and benefits. The authors believe that since most students in state universities are young adults, their health financing requirements are very similar. To this end they recommend the development of a single product and brand it accordingly.

The health insurance plan should pay for consultation and treatment received from government, mission, municipal and private hospitals, general practitioners and specialists up to a limit, per student per annum.

### **Registration of the fund with the authorities**

The technical committee should be mandated to register the proposed medical

benefit fund in terms of the Medical Services Act, Chapter 15: 13; Companies Act, Chapter 24:03 and any other applicable and enabling legislation.

### **Administration**

The technical committee should consider the following issues that affect the efficient running of the business of the proposed medical benefit fund.

#### *Location of registered office and other offices.*

This could be either in Harare or Bulawayo with satellite offices at all state universities. Any other center could be considered for the location of the head office. The authors' suggestion is based on the density of service providers in Harare and Bulawayo. Most members would be referred to these big centers for specialist medical tests and treatment. Existing facilities could be used as satellite offices. For example, the existing medical clinics could be expanded and resourced to offer a variety of services normally available from general practitioners. Besides offering added convenience this strategy will also save on costs in the long term despite the initial minimal additional capital outlay.

#### *Staffing issues*

Additional staff will be required especially for the head office. This will include the principal officer, finance manager, internal auditor, membership and claims administrators. However, they should be very few, because most of the work will be done from satellite offices. Initially there may be a lot of work when the office is set up but that should stabilize with the effluxion of time.

#### *Finance and claims administration*

This could be centralized at head office and payments to service providers and refunds to members made once every fortnight i.e. only on two occasions per month.

#### *Dispensary*

It is advisable to buy the essential drugs from source to save on costs and keep them in stock for use by members. Railmed, a medical benefit fund wholly owned and operated by the National Railways of Zimbabwe for the benefit of its employees, pensioners and their dependants, currently operates such a facility countrywide. The state universities should use the existing medical clinics at their campuses for

a similar purpose. Although most state universities clinics are Group C facilities in terms of the Medicines Control Authority of Zimbabwe, they can easily upgrade to Group B status so as to be allowed to dispense most drugs including antibiotics and antiretroviral drugs. Alternatively, mutually beneficial schemes (drug facility schemes) can be arranged with leading private pharmacies to allow members' access to drugs without paying for them upfront. Payment will then be made by the fund directly to the pharmacies on submission of their claim documents.

### **Approved service provider network**

For the members to benefit, the scheme should be promoted for broader acceptance by as many service providers as possible so that members are not inconvenienced in the time of need. The management of the medical fund should promote the scheme and establish working relationships with as many health service providers as possible. This can also save on cost as it is possible to negotiate preferential rates.

### **Access to technical advice**

The state universities have a large pool of experts on their payroll some of whom extensive practically acquired experience in life and health insurance administration. The technical committee should tap on that expertise for any advice they may need. This will not only serve on costs but show the world that academics do not only generate new knowledge for the benefit of mankind but also practice what they preach!

### **Conclusion**

Emerging trends in risk management indicate that more organizations worldwide are electing and adopting funded risk retention strategies in an effort to contain cost and get more value for their money. The underfunded state universities in Zimbabwe should embrace this philosophy and design and implement innovative and robust enterprise wide risk management strategies that mitigate the risks they are exposed to. For a start, establishing a unified independent medical benefit fund to finance the student health expenses will be a step in that direction. It is not only practically possible but also a strategy that can be used to provide better medical benefits for the already financially burdened students at minimal cost.

**References**

- Bawcutt, P. (1997). *Captive Insurance Companies: Establishment, Operation and Management*, Witherby, London.
- Bayes, N.L., and Keller, C and Valerius, J. (2002). *Glencoe Medical Insurance*, McGraw-Hill, New York.
- Bayes, S.T.. (2010). Paper on the *Liquidity Crunch* presented at the ZNCC Congress 14-16 July 2010, Bankers Association of Zimbabwe, Harare.
- Government of Zimbabwe (1998). *Medical Services Act: Chapter 15:13*, Printflow, Harare.
- Government of Zimbabwe (2011). *2011 Second Quarter Treasury Bulletin available online at [www.zimtreasury.org/downloads/913.pdf](http://www.zimtreasury.org/downloads/913.pdf)* accessed 16 October 2011.
- Insurance Council of Zimbabwe (2007). *The Insurance Survey 2007*, The Zimbabwe Independent, Harare.
- PSMAS (2010). *Notice to Members, Information Bulletin*, PSMAS, Harare.
- PSMAS (2011). *Notice to Members, Information Bulletin*, PSMAS, Harare.
- Roosenbloom, J.S. (2005). *The Handbook of Employee Benefits*, 6<sup>th</sup> Edition, McGraw-Hill, New York.
- Skipper, H.D., and Kwon, W.J. (2007), *Risk Management and Insurance: Perspectives in a Global Economy*, Blackwell Publishing, Oxford.
- Valsmakis, T, Vivian, RN and Du Toit, G.S. (2002), *The Theory and Principles of Risk Management*, Butterworth's, Durban
- Zimbabwe National Statistical Agency (2011), *Zimbabwe Consumer Price Index October 2011*, ZIMSTATS, Harare.