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When too much is not enough: capital in a mutual health fund

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Abstract

Not-for-profit, or mutual, health insurers are not constrained in their use of capital in the same way as for-profit insurers which are accountable to a parent financier or to the capital markets. In some respects, this affects the minimum capital that each needs to hold. However, the question arises also as to whether capital accumulation in a mutual should be constrained when it mitigates risk and also allows lower prices and better benefits than those of for-profit competitors.

This question is particularly apt in the current Australian private health insurance market where there has emerged a mixed structure of not-for-profit, for-profit and hybrid firms, and where all insurers are being required by the regulator to set and justify explicit capital targets.

This paper explores some of these issues.

Keywords: capital, health insurance, mutual, for- profit, not-for-profit, shareholders, prudential, economic, market, pricing, discount, benefits, efficiency, regulation.

1. The issues

Everything is vague to a degree you do not realize until you have tried to make it precise.

Bertram Russell

1.1. The issue

1.1.1 The role of capital within the private health insurance industry in Australia has been discussed by actuaries from time to time over many years, but it has become particularly topical since 2010, when the industry regulator required insurers to develop capital management plans. This has put on the agenda of every insurer the setting of capital objectives and the management of capital itself. It follows a gradual evolution in attitudes towards the roles of capital within an industry that has been dominated by not-for-profit mutuals throughout most of its history. During the past twenty years there have been considerable changes in the structure of the market, and there is now a mixture of for-profit and not-for-profit insurers competing for business under common regulations. Further, the effects of the recent global financial crisis, and the associated investment volatility experienced by numerous financial institutions, has added cogency to the practical concerns of directors and others managing capital within all financial institutions.

1.1.2 The question arises as to how the differences in capital structure, particularly between a for-profit and a not-for-profit insurer, affect the proper management of capital. This paper explores the issue from the perspective of a not-for-profit or mutual health insurer.

1.1.3 In this paper I will use the terms *shareholder* and *for-profit*, to denote generally the form of capital structure where there are investors, as stakeholders distinct from customers, employees and others, who provide capital to finance the business in the expectation of receiving rewards from profits. I will use the terms *mutual* and *not-for-profit* to denote generally the form of capital structure where there are no investors as separate stakeholders with an expectation of reward from profits. I recognise there can be subtle distinctions within these two structures, and also that there are hybrid forms where there is, for example, an inter-related group of companies which contains both forms. This paper is not concerned so much about legal niceties or subtle differences in governance or complexities of organisation within groups. Rather, it seeks to explore issues arising in the management of capital where there are no investors whose primary motive is profit.

1.2. Literature

1.2.1 There is a considerable literature on capital management issues for shareholder or for-profit organisations but, to my knowledge, that relating to mutuals is somewhat rarer. In a widely cited paper Redington (1952) discussed some of the capital management issues for actuaries in the context of a mutual life insurer, and he coined the term *estate* to describe the accumulated free reserves. Baumol (1967) has written extensively on business activity where motives other than profit are prominent. Pollard (1978) addressed the issue of holding capital in a general reserve to mitigate risk, in the context of what was then a wholly mutual private health insurance industry. Gale & Watson (2007) reviewed the development of the industry, including the evolution of its current mixed capital structure. In Carroll (2007), I discussed some of the issues relating to capital accumulation in a mutual, and it is to amplify some of those ideas that I have written this paper.

2. Capital in the industry

Success is the ability to go from one failure to another with no loss of enthusiasm.

Winston Churchill

2.1. The private health insurance industry

2.1.1 While many developments in Australia mirrored those in many western societies, the health insurance industry has evolved largely as a substitute for the kind of government schemes introduced elsewhere in the early twentieth century. Attempts to legislate welfare systems like those in Europe and America were frustrated by ideological and constitutional issues and private health insurance spread in this vacuum. Friendly societies flourished and many medical and hospital interests established organisations modelled on the Blue Cross funds of the USA, with coverages designed to complement their private health interests.

2.1.2 Following the Second World War, the Menzies government provided a legal framework for the continued growth of private health insurance, with the National Health Act 1953, and the industry evolved its unique Australian form under this regime. While voluntary particpation was a central principle, features such as community rating and pay-as-you-go financing duplicated the features of many government sponsored schemes elsewhere.

2.1.3 In 1974, the Whitlam government used a joint sitting of the Parliament to enact a government health insurance scheme, then known as Medibank, which made coverage virtually universal. The subsequent Fraser government diluted Medibank, but in 1983 the Hawke government re-enacted it as Medicare, and this has survived now in its essential form for almost 30 years.

2.1.4 Medibank and Medicare destabilised the underlying demographics of the private health insurance industry, and set off a spiral of rising average claims and contributions in what remained a community rated system with voluntary membership and virtually no accumulation of actuarial reserves. A risk equalisation scheme was established to help diversify exposure to bad risks across all insurers. Tax incentives, subsidies and new pricing rules were introduced to encourage participation by healthy policyholders, and the prudential regulation of the industry was strengthened with mandatory minimum reserves and actuarial reporting. These measures have stabilised the industry, which appears now to have settled at an equilibrium with coverage at about half the total population.

2.1.5 Since the establishment of Medicare and the subsequent period of instability, there have been some significant changes in structure among the private health insurers, including demutualisations and mergers, and the industry now comprises a variety of for-profit and not-for-profit insurers engaged in intense competition with one another.

2.2. Evolution of capital rules

2.2.1 In 1987, two organisations sought and received licences to operate on a for- profit basis in what was then overwhelmingly a not-for-profit industry. Neither resulted in change of any significance in the industry: one never commenced operations and the other never achieved more than a 1 percent market share. The view widespread at the time was that investment in private health insurance in Australia was unlikely to be profitable under the rules then applied by the regulators, despite a high uptake of and substantial expenditures on private

health insurance by the Australian population. Other Australian financial institutions occasionally entered shared distribution arrangements with established health insurers, but few sought to enter the market as a producer themselves. A number of large international insurers spread their operations internationally, including for example to South Africa and New Zealand, but pointedly chose to avoid the Australian market.

2.2.2 Before 1989, private health insurance in Australia was often described by external observers as a *cottage industry*. Although it had large cash flows, it operated almost wholly on a non-profit basis, with small margins and few capital resources. It had none of the customary tools of actuarial management: there was no underwriting, no risk rating and no reserving for accumulating liabilities. The industry relied upon social solidarity, whereby good risks subsidised bad, and the government often intervened on an ad hoc basis adding to a complex raft of regulations and rules designed simply to maintain financial stability.

2.2.3 Insurers were prevented from accumulating capital. Pollard (1978) documents in some detail the attitudes expressed by regulators during the period 1961 to 1978, including for example (para 7.5):

> *1970 - Government policy declared to be a limit of three months' contribution income – small funds to be allowed to exceed the limit in appropriate circumstances*.
>
> *1971- Department of Health reminded funds of Government policy that free reserves should approximate three months' contributions for larger funds and up to six months for smaller funds. A gradual reduction in reserves from higher levels over up to five years.*

2.2.4 Attitudes to capital management were however evolving. Most notably, a regime of minimum reserves, as Pollard had advocated, was introduced with the establishment of the Private Health insurance Administration Council ("PHIAC") in 1989.

2.2.5 The turning point came in the early 1990s, as a consequence of the financial difficulties of HBA in Victoria and Mutual Community in South Australia, which were rescued from financial insufficiency with an injection of capital by the large life insurer, National Mutual, leading ultimately to their demutualisation.

2.2.6 At this time, the industry was under considerable stress in the wake of Medicare. There was intense competition for the remaining health insurance business. New risk equalisation rules meant the benefits from cherry-picking among good risks were reduced, and many niche funds were under similar financial pressures as the large open funds had been: the pain was being shared around. PHIAC was imposing new prudential disciplines and insurers that the infringed them were required to obtain actuarial advice, and this placed a spotlight on long term capital issues.

2.2.7 Elsewhere in financial markets a wave of demutualisations and other structural changes in capital management were already occurring. The life insurance industry in particular, already under competitive pressure due to its inefficient distribution systems, went into decline after the stock market crash of 1987 and a consequent *flight to security* by retail savings into the banks.

2.2.8 Private health insurance was also in decline, from coverage of over 50 percent in 1984, down to almost 30 percent of the population in 1996 when the Industry Commission commenced an inquiry into the industry. There followed more reforms, including new tax incentives and pricing rules, a two-tiered system of solvency and capital adequacy, a

tweaking of the risk equalisation system, and routine actuarial monitoring. These reforms were associated with a rebound in coverage to almost 50 percent of the population, and were consolidated in the Private Health Insurance Act 2007 and associated Regulations.

2.2.9 The period following the advent of Medicare was marked also by changes in attitudes within the industry. The rejuvenation of HBA and Mutual Community, under the direction of a profit-driven shareholder, had an effect on other health insurers. Competition increased, with more innovation, a softening of the market segmentation across States and a rise in more efficient media for distribution and communication, including the internet. Not least was the dramatic increase in profit and value achieved by National Mutual/AXA from 1991 and BUPA from 2002 as owners of the demutualised entity.

2.2.10 Gale and Watson (2007) give a comprehensive history of the structural changes in the industry. Following the take-over of HBA and Mutual Community in 1990, there were more demutualisations: SGIO in 1997, Grand United in 1999, Australian Unity in 2001, and NIB in 2007. Also in 2007, NHBA was established on a for-profit basis, and in 2008 three established insurers, AHM, MBF and Manchester Unity were demutualised and acquired by Medibank Private, BUPA and HCF respectively. In 2009, Medibank Private, owned by the Commonwealth Government, was converted to for-profit status.

2.2.11 In its 2009-10 Annual Report on the Operations of the Private Health Insurers, PHIAC reported that 10 insurers operated on a for-profit basis as at 30 June 2010, "accounting for 70.4% of total market share." Arguably, just four of these - NIB, NHBA, AHM and Medibank Private - are fully demutualised. The other six – BUPA and its subsidiaries, the former SGIC and MBF (both subsequently merged into BUPA), Australian Unity and Grand United, and Manchester Unity - are held within corporate structures that are ultimately owned by not-for-profit mutuals, to which I refer as hybrids.

2.2.12 The table below summarises the mix of insurers as at 30 June 2010, as reported by PHIAC. The capital is that attributable to the insurers' health insurance business, and the premiums are the amounts attributable to the past twelve months.

	Number of insurers	Coverage (millions)	Capital ($billions)	Premiums ($billions)
Pure for-profits	4	4.3	2.1	5.2
Hybrids	6	3.7	0.8	4.8
Not-for-profits	27	3.6	2.3	4.2
Totals	37	11.6	5.3	14.2

The table below shows the coverage, capital and premiums in percentage market shares. It also shows the average *solvency capital risk multiple* for each group, which relates the total capital held to the total solvency reserves calculated according to PHIAC rules.

	Coverage	Capital	Premiums	Solvency
Pure for-profits	37%	41%	37%	2.81
Hybrids	32%	15%	34%	2.58
Not-for-profits	31%	44%	30%	3.60

2.2.13 It is apparent from the tables above that the for-profit insurers, although fewer in number, now have a significant market share and that, compared with the not-for-profit insurers, they are retaining less capital within the health insurance components of their businesses.

3. Capital in a mutual

Capital as such is not evil; it is its wrong use that is evil.

Mohandas Gandhi

3.1. Attitudes

3.1.1 In Carroll (2007), I reviewed some of the changes in attitudes to capital that have occurred in the Australian private health insurance industry. I have also referred to these elsewhere in this paper too. In many financial markets, more rigorous prudential regulation, greater demand for products and services which require capital inputs, and greater awareness of the risks and rewards from investment in a variety of financial assets, have lead to changes in capital structure and, where large mutuals once dominated the banking and insurance industries, this is no longer the case. These developments have affected health insurers too.

3.2. Reasons for holding capital

3.2.1 I have also previously described the general reasons for a private health fund in Australia to hold capital. Essentially these are defensive and assertive.

- *Defensive capital* - the industry has a long history of prudential failure of both large and small funds, and occasional failures still occur. The orderly management of these failures is facilitated by PHIAC, which has gradually brought some capital discipline to insurers as aprt of this process, with solvency and capital adequacy requirements and, recently, capital management planning .

  Risk is intrinsic to the nature of the business, and there is no level of capital that can totally immunise a private health insurer against ruin. It is technically possible to reduce the risk of ruin to any given level of probability by holding appropriate levels of capital, but there always remain uncertainties that cannot be immunised.

  There are also risks that are political in nature, sometimes referred to as sovereign risks, associated with operating private health insurance in Australia, sufficient to deter from entry many global health insurers and large domestic financial conglomerates.

  One response to the uncertainties inherent to the business, and to the substantial political risks in the Australian private health insurance market in particular, is the accumulation of capital reserves.

  Assertive capital – access to substantial assets also confers competitive advantage on a private health insurer. They assists price stability during the long lags that occur in the observation, assessment and considered responses of the insurer to continual changes in its experience. Capital margins facilitate good management and planning, they support autonomy and morale within an organisation, and they can allow advantage to be taken of favorable growth and acquisition opportunities.

  It is far easier to manage an insurer with a strong balance sheet than one experiencing continual capital shortages. With accumulated reserves and access to capital resources, an insurer is more likely to retain control over its affairs, to have high morale among its staff, suppliers and customers, and to withstand disastrous downside events.

Most significantly, in the case of a mutual, capital allows lower effective pricing, and higher benefits, than would be possible in the absence of the capital or if investment earnings were required to support dividend payments to investors. The use of investment earnings to subsidise prices and benefits provides a return on capital to policyholders similar to the payment of dividends to shareholders.

3.3. Differences attributable to capital structure

3.3.1 Mutuals are often formed in communities where there are needs that are not being met by profit motivated firms. Their objectives may in part be social or philanthropic, and they may be sponsored by prominent citizens who offer useful political and financial support.

3.3.2 One feature that is usually significant in the success of a mutual is the bond: a strong sense of community solidarity that permeates the culture of the organisation. This can create cost advantages, for example from the use of voluntary labour, access to cheap methods of selling and distribution, and low levels of default on financial obligations.

3.3.3 All insurers have in their core an irreconciliable conflict of interest between two groups of stakeholders: policyholders who make claims and those stakeholders who have capital at risk. For a mutual insurer, this conflict is diminished. Differences of interest among policyholders who are claiming and the other stakeholders are ameliorated in a mutual by the bond although, ultimately, a generous approach to claims has actuarial consequences for any insurer. Arguably, insurance markets with a mixture of mutuals and for-profits, competing among one another on more than just price and profit, can achieve a natural equilibrium between justice for those who do claim and value for those who do not.

3.3.4 Mutuals can become more difficult to manage as they evolve. Increases in size and scope can be accompanied by a weakening of the bond among the stakeholders, and increases in complexity can cause a loss of efficiency in the absence of a clear profit objective. Without explicit accountability to capital markets, the use of capital can become a source of controversy. Many mutuals that grow in size and complexity resolve their dilemmas by choosing to demutualise and thereby separating explicitly the roles of customer and owner.

3.3.5 The long term strategic management of a mutual is often likened to the parental role in a family dynasty, where the organisation's wealth and culture is celebrated as something valuable to be nurtured, sustained and passed on. Wise stewardship of the organisation is often measured by its continuing growth and financial strength as it passes from generation to generation of stakeholders. Managing the capital of a large mutual life insurance company has been often been referred to as *steering the estate*.

3.3.6 For-profit insurers look to investors, as a set of stakeholders separate from customers, to provide capital, to establish or acquire the business and to supplement its requirements as necessary. Mutual insurers accumulate capital from their customers a byproduct of their overall customer relationships. A number of other differences are apparent.

- *Governance* –in a for-profit insurer, the investors typically have a dominant role in the appointment of directors and in the management of the business. This role may be abridged in unusual situations, if for example a default occurs on an obligation or there is intervention by the regulator but, normally, it is to the capital stakeholders that the insurer is primarily accountable. In a mutual, the directors are appointed by a political process such as by popular vote of the customers or of a subset of the customers.

- *Mobility* - where capital is subscribed by investors, it is generally mobile and can be supplemented or withdrawn in response to changes in profitability or business opportunities such as acquisitions. Investors can vary their stake independently of their status as a customer. In a mutual, the capital is usually accumulated from customers by a gradual process of conservative financial management over an extended period, and is relatively immobile and not readily supplemented.

- *Clarity of purpose* - the presence of governing stakeholders with a profit motive helps clarify the objectives and focus of the directors and management. In a mutual, the motives of the directors can more readily include a variety of financial and social objectives. The focus of the management can be diffuse and, often, unclear. Baumol (1967) famously modelled many of the behaviours that can arise in such circumstances including, for example, unprofitable growth.

3.4. How much?

3.4.1 The minimum capital required by a health insurer generally must have regard to a number of criteria, including the following.

- *Economic* – like any business, a health insurer requires working capital to support its activities as an operating and trading entity, with obligations for employees, premises, equipment, utilities, marketing and sales and compliance. In addition to that, arising from the nature of the business of the insurance in which it is engaged, it is exposed to a variety of operational and environmental risks, such as fraud, theft, sabotage, damage to or loss of key resources, sovereign risks such as changes in tax or regulation, and changes in the conduct of complementary businesses such as health service providers. Further, an insurer is exposed to all the forms of risks related to dealing in financial assets and liabilites pertaining to its future obligations, which include overestimating the values of assets, underestimating the values of liabilities and misjudging pricing. Capital is required to underwrite all this exposure to risk and uncertainty.

- *Prudential* - under the present regulatory regime there are prescribed accounting rules relating to the estimation of provisions, such as those for advance premium payments and unpaid claims, and prescribed solvency and capital adequacy rules. Failure to meet these invites intervention by the regulator and puts the autonomy of the insurer at risk. Insurers generally hold margins in excess of the formal minimum requirements to reduce the risk of a breach.

- *Market* - companies that raise finance externally are exposed to competition in the capital markets, and consequently to external assessments of their governance, management, labour relations, profitability and risk mitigation. They may be routinely subjected to ratings, request for explanations and to public scrutiny, comment and speculation. The capitalisation of the insurer must be considered having regard not just to economic need and prudential constraints, but in response to market judgements too.

3.4.2 These criteria for the minimum capital requirements are not additive, but each component sets a minimum threshold. A for-profit insurer must have sufficient capital, on its balance sheet or readily accessible, to meet the most demanding of the economic, prudential or market requirements. For a mutual, the criteria for setting the required minimum capital are essentially similar but, except in the unusual circumstances where it has a desire or need to raise external finance, the need to meet expectations and disciplines of the capital market are absent. Strictly therefore, other things being equal, the minumum capital required in a

mutual is no more than, and in some cases less than, that required in a for-profit insurer in comparable circumstances.

3.4.3 In practice, for-profit insurers tend to avoid holding undue capital above the minimum requirements of the business, while mutuals do not. Capital from profit-motivated investors seeks its most remunerative use among all the investment opportunities available to it. Where profit is the motive, increases in resourcing are driven by the marginal profitability of additional inputs. In the case of capital, this profitability test is often expressed in terms of hurdle rates. Investor capital is a costly resource and a for-profit insurer will tend to avoid holding more than is justified by its marginal profitability.

3.4.4 The accumulation of capital in a mutual is not so constrained by profitability. Mutuals are financed from a process of gradual accumulation from their operations and, normally, capital cannot be supplemented quickly or in large amounts. Additional reserves are usually accumulated simply as a ready source of finance to meet unexpected consequences and mitigate risk from the inherent uncertainties of the business. When discussing Redington (1952), R J Kirton referred in the context of a mutual life office to: *"… an idea of great importance.. that there existed or should exist one way or another a body of free reserves carrying interest. Those free reserves – the estate- were augmented from time to time , drawn on from time to time .. the cushion which, through major fluctuations that would inevitably occur.. should protect the life fund."*

3.4.5 Once capital is accumulated in a mutual, it is available to further the full range of objectives of the insurer, without a need to afford returns to investors. In Carroll (2007), I discussed its use to enhance the general management and opportunites of the insurer, using a somewhat colourful aviation metaphor of flying at different altitudes over variable terrain and in unpredictable traffic and weather conditions.

3.4.6 It is a matter of interest how it is possible to exploit the accumulating assets of a mutual in the current Australian private health insurance market to achieve a price advantage over for-profit competitors. This is addressed in the next section.

4. Using capital competitively

The difficulty lies not so much in developing new ideas as in escaping from old ones.

John Maynard Keynes

4.1. Capital strategies

4.1.1 The commonly held view of some years ago, when the private health insurance industry was wholly mutual and was regulated without even minimum capital requirements, was that accumulating capital imposed unnecessary costs, and was inequitable across the different generations of policyholders. This argument of course is not relevant when the capital is subscribed by external investors, as is now the case for 70 percent of Australians covered by private health insurance.

4.1.2 In the case of a mutual, the equity argument is weakened when policyholders participate continuously over long periods, during which they both contribute to and benefit from the capital. The advent of lifetime health cover has encouraged continuous long term participation, and it can now be more widely accepted that, in a mutual, the costs of accumulating capital are temporary, the benefits are enduring, and the equity implications are not significant among long term participants. Even short term participants in a mutual with a large estate have, arguably, made their choice in a free market offering competition from both the for-profit alternatives and other mutuals.

4.1.3 It is my view that the ability to accumulate capital, and pass it intact from one generation of participants to another in a mutual, confers an advantage on mutuals which can be used to offer competitive customer value, and this is discussed below.

4.2. Lower prices

4.2.1 The conditions under which the earnings on the estate of a mutual can reduce prices without weakening the capital position can be demonstrated algebraically as follows:

Let A(t) be the estate of the mutual insurer, P(t) be the average premium rate and N(t) be the number of pricing units, growing respectively at rates i, f and g per unit of time t.

Then, if $0<k<1$ is the proportion retained from the growth of the estate between t and t+1, for the estate to be maintained in proportion to total revenues after distributions are made from the growth in the estate, we have:

$$\frac{A(t+1)}{P(t+1)*N(t+1)} \geq \frac{A(t)}{P(t)*N(t)}$$

$$\frac{A(t)[1+ki]}{P(t)(1+f)*N(t)(1+g)} \geq \frac{A(t)}{P(t)*N(t)}$$

$$[1+ki] \geq (1+f)*(1+g)$$

$$ki \geq f+g+fg$$

4.2.2 Put another way, so long enough of the earnings are retained so that the growth of the estate matches the growth of the premium revenues, subsidies from the estate can be made without weakening the capital position. This provides a mutual with the opportunity of a competitive pricing advantage over a for-profit competitor.

4.2.3 Each of i, f and g can be assessed, historically and in the context of a particular mutual at a particular time, in considering issues of capital accumulation, pricing and growth. Generally, the estate does not need to be matched to specific liabilities, and it can be invested for high long term returns. The growth in participation in an established mutual is typically close to the growth in participation in the market as a whole. Movements in competitive premium rates ultimately reflect movements in the prices of the underlying health services and chnages in the scope of the insurance coverages being offered.

4.2.4 More sophisticated modelling, including the dynamics of the relationships between capital accumulation and pricing over extended periods, may provide useful tools for a mutual seeking to use capital for competitive advantage. Further development of these ideas may be particularly apt for the current private health insurance market, where vigorous competition is occurring between the differently structured insurers, and where the regulator is giving attention to the setting of capital objectives by insurers.

4.3. Benefits and efficiency

4.3.1 The earnings on an accumulating estate in a mutual can be used also to enhance benefits, for example by assisting difficult claims assessments, supporting ex gratia benefits, subsidising wellness programs, promoting loyalty rewards, and in other ways consistent with the financial and social objectives. The ability to accumulate and use capital in an assertive manner to improve value to all its stakeholders, helps differentiate a mutual in its customer relations generally and the promotion of its social and community roles.

4.3.2 Arguably, mutuals are more susceptible to economic inefficiency than are their for-profit competitors, which are subject to more direct accountabiltity for their use of resources. The ability of a mutual to use accumulated capital it to subsidise premiums and enhance benefits can compensate for this.

4.4. Implications for regulation of capital

4.4.1 The use of accumulated capital in a mutual does provoke market responses. Mutuals which successfully use capital to enhance customer value may attract more growth in their business, and that dilutes the capital.. The analysis in 4.2 above suggests that more growth in the business requires more of the estate to be retained, and less is then available for reducing reducing prices and enhancing benefits in subsequent periods. This suggests a dynamic, that limits distributions from the estate during periods of growth and allows it more during periods of stagnation, in a manner that is self-equilibrating.

4.4.2 On the other hand failure by a mutual to use accumulated capital, to the satisfaction of the stakeholders who hold the directors accountable, can attract the attention of profit seeking entrepreneurs, with the ultimate possibility of demutualisation and take-over. There is a dynamic in capital markets that limits lazy capital accumulation within mutuals. Recent competition for the future control of GMHBA, a mutual, by the directors of NIB, a for-profit, illustrate capital market competition at work. Mutuals now compete in an industry

where access to resources and customers is vigorously contested, and are exposed to the market disciplines in their use of capital in a manner which is also self-equilibrating.

4.4.3 The role for a regulator can usefully include facilitating effective governance, that keeps the directors of mutuals accountable to the stakeholders who have the ability to replace them, or to accept a takeover offer. Beyond that, it is difficult to see any economic or actuarial reason why the accumulation of capital within a mutual should be constrained by a regulator as well as by the markets. There is now a variety of mutuals and for-profit insurers, all competing to offer value both for premium outlays by consumers and for the use of capital within the industry. The directors of mutuals determine the pricing and capital accumulation strategies they consider best for their particular market situation, and restraining them by regulation from doing so merely weakens their ability to compete.

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5.3. Nevertheless, all the opinions, errors and omissions are entirely my responsibility.

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