ASSOCIATION OF CONSULTING ACTUARIES

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DP18/10: Patient Capital and Authorised Funds

This document sets out the response by the Investment Committee of the Association of Consulting Actuaries to the discussion paper of the above name issued by the Financial Conduct Authority on 12 December 2018.

ACA Response

Q1: Do the category limits strike the right balance between enabling retail investments in patient capital while ensuring investors can redeem their investments in a timely manner? If not, what changes should be made to existing structures?

If the assumption is for these types of funds that investors need to redeem in a timely manner then there will always be a limit to the extent that these funds can make investments in patient capital. This also relates to question 2, however if one of the key objectives is to be able to redeem in a timely manner then it would make sense to maintain the relatively tight restrictions (particularly) on UCITS funds so that there is a clear identification for investors as to the type of funds they are entering.

The other consideration is around what is considered as timely, this is currently defined by many as daily however this would need to be extended quite considerably in this type of framework and may even extend to lock-ups and quarterly/annual liquidity. If a member does not have need for the capital in a short timescales then these may still be considered reasonable even if these may not be "timely", i.e. there is an argument that there is less need for the timely element if an investor knows and understand the underlying assets are more illiquid.

Q2: Is there a retail investor demand for a new type of authorised retail fund which can, for example, invest all its capital directly into patient capital assets?

Although we have not carried out any market research we believe there is from discussions and anecdotal evidence a demand for funds which can invest in patient capital. In particular this would make sense for younger DC investors who have no intention of withdrawing money for possibly the next 20 – 30 years.

Investment analysis may indicate that returns from some assets that would be considered in the "patient" capital spectrum would produce beneficial diversification. For a retail client base however it may be difficult to understand the risk return profile between different asset classes

Another area that we think should demand attention is to ensure that any patient capital funds do not load up on cash to ensure liquidity is available for investors. This may provide liquidity but would likely dilute beneficial other elements and would lead to investors paying high fees for cash allocations. As a result our preference would be try to find a balance between a regime that allows managers to invest predominately in patient assets whilst ensuring investors are fully informed about the risks.

Q3: If authorised funds marketed to retail investors were permitted to hold more patient capital, what safeguards do you think are needed to adequately protect investors?

When dealing with assets that could be included in patient capital there are potentially a much wider range of risks that would need to be considered. These can include but are not limited to:

- Fees: Will generally be higher in these asset classes and if you are locking up capital you will not be able to redeem if a key manager leaves for example.
- Value assessment: Given the long lead times to see performance come through in these types of assets it can be difficult to assess value and skill in a timely manner.
- Complexity: These assets are generally more complex to understand and to manage.
- Diversification: It can be harder to create diversification, especially if a fund is small as buying small pieces of infrastructure projects or private equity investments isn't easy.
- Cash holding: If the fund takes in all capital when it is committed then given the difficulty of deploying many of these assets they may sit in cash for a considerable period of time, bringing down the potential returns available.
- Deal sourcing/expertise: Ensure that strong due diligence is done on the managers and fund. This could protect investors from the risk of investing in a fund that does not have adequate access to the desired investments.

In implementing funds that could hold more patient capital some of the safeguards that could be included would be:

- Advice required: Retail investors would have to receive advice from an IFA or other regulated advisor in order to implement an investment.
- Secondary Market: Assisting the industry to create a secondary market where shares in closed ended funds could be easily traded in and out of.
- Fee transparency: Given the range of additional costs that can be involved, clear transparency in where the fees are being paid and who to.
- Diversification requirements: A minimum level of diversification, which may in reality create a minimum fund size however this is probably a good thing for overall investor protections.

Q4: Should NURSs have a broader ability to finance infrastructure projects than is currently possible under our regime? If so, what changes do you think are necessary to our handbook?

Infrastructure projects can cover a wide range of different types of investment and as noted under the current regime it may be difficult to invest for NURSs where there is no freehold or leasehold. It may also be that these are the more risky projects and as such it does create some element of protection for investors. Although it would be beneficial to allow more investors access to infrastructure investment it may make more sense to delineate between funds and allow a new type of fund to invest in a wider range of patient capital assets including infrastructure. If the government wanted to look at wider solutions then one of the main issues is how do investors leave if they needed to in an emergency. It may be helpful if the government could facilitate with the industry a secondary market or platform that would allow investors to redeem (potentially at a discount) much more easily than they currently do. If this was in a platform format then it would also be ideal if current daily dealing platforms could plug into it to enable their investors to access patient capital assets in a regulated environment.

Q5: Do the current rules governing QISs provide professional and sophisticated retail investors with sufficient access to patient capital? If not, why not and what changes do you think are necessary to our handbook?

No comment.

Q6: If QISs are permitted to hold more patient capital what safeguards do you think are needed to adequately protect investors?

Protecting investors in this context should be about ensuring that investors understand the risks they are undertaking when investing in the structure and that managers provide clear and consistent information such that investors can do fair comparisons. One of the issues with this in the patient capital space is that asset classes can be very different in their risk and return profile in particular in relation to the true liquidity, the income distribution and the risk factors.

Creating a consistent framework for assessing investments in patient/illiquid investments would be very beneficial. As part of this it may make sense to have some predefined stress tests by the regulators as assessing these types of investment on a volatility or drawdown perspective makes little sense.

It would also make sense to ensure that investment managers set up liquidity requirements that are genuinely consistent with the underlying assets as this will protect investors by ensuring that the risks are clear and also in the event of a liquidity event.

Q7: Do the current diversification rules strike the right balance between investor protection, by requiring a prudent spread of risk, and sufficient access to patient capital? If not, do we need a different or more flexible approach to diversification rules?

We are not fund managers however as consultants we would not want to see more limited diversification particularly in the area of illiquid assets (patient capital). By this we mean diversification within a sleeve of patient capital assets e.g. infrastructure funds holding at least 20 - 30 projects, rather than diversification across sleeves.

We can understand why managers may want to be very prudent in respect of the diversification limits, for example holding significantly less in an asset than is permitted by the regulations where the manager is dealing with more illiquid assets. On the other hand the reason the manager is generally being more diversified than they need to be is because they understand how illiquid these assets are and therefore costly and inefficient reshaping the portfolio can be if they breach. In effect this behaviour recognises that illiquid assets are likely more risky than liquid assets where it is very easy to cheaply and efficiently reshape the portfolio. Based on this we believe it would probably make sense to have different restrictions for illiquid and liquid assets as at the moment the illiquid restrictions are effectively being inferred from the current ones.

Q8; If authorised funds scope to invest directly into patient capital assets other than immovable is increased do we need a remedy similar to the proposed mandatory suspension to avoid investors being treated unfairly? If you believe the suspension rules would be appropriate, please set out your suggestions as to what such a remedy would look like. If you do not suspension rules would be appropriate please explain why not.

It would make sense that if a fund is holding more assets that are difficult to value given there is a limited market that there should be mechanisms put in place to ensure that investors are not treated unfairly. A mandatory suspension would be one method of doing this however it can lead to a lock when a fund only has a proportion of its assets in difficult to value assets.

An alternative option may be the concept of side pockets such that if there was a small proportion of the fund that held an asset with an uncertain price that can be moved into a sidepocket such that all investors receive a slice equal to their investment but it would allow the continued functioning of the rest of the fund. This would be less applicable if the entire fund was invested in an asset that was difficult to value and due to this it would make sense to give the fund manager the choice as to which option to implement.

Q9: Why do you think the specialised funds have not been used in significant volumes?

This is difficult to say given we do not have direct experience with these funds however it would seem likely there is limited knowledge surrounding these products and unless there is client demand for these then it is unlikely that a fund manager would set them up given the overheads of understanding them.

We discuss DC specific reasons in Q11 below.

Q10: Are there specific features of these funds which prevent fund managers or investors from using them to invest in UK Patient Capital?

Platform infrastructure which is geared for daily dealing funds creates a challenge – we discuss this further in Q11 below.

Q11: Are there other areas where the current regulatory framework creates unnecessary barriers, either directly or indirectly, to investing in patient capital?

These are certainly useful things to have and there are investors who can tolerate illiquidity, such as younger DC investors. Although there may be fund structures that could work for them, they are not easily accessible because DC investors for most schemes (excluding very large schemes) need to invest via platforms. Platforms do not feel able to accommodate these funds.

Our view is that there are potentially larger barriers in the intermediation market, particularly for DC investors where they need to access investments often via platforms. While not a regulatory barrier, some platforms find it difficult to accept non-daily dealing funds as part of BAU processes and systems streamlined for daily pricing and liquidity. However, platforms can accommodate patient capital when forced, as seen during the middle of the decade when a number of popular (in DC) property funds gated.

The 0.75% DC fee cap creates two challenges:

- Funds of this nature (as available today) are expensive
- Funds of this nature tend to have a performance fee element as standard. The fee cap makes this unworkable as there is no guarantee performance fees won't drag total fees over the fee cap. Either these funds are non-runners, or non-performance fee share classes are used, some of which come with fees approaching 2%.

Combining high fees with the point above about some of these funds having cash allocations to guarantee liquidity, DC schemes therefore can only make small allocations to patient capital, with even smaller true patient capital exposures (as it stands today).

We would like to see a greater push by regulators to make it clear that provided certain conditions are met that intermediaries can more easily help investors to invest in less liquid asset classes.

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Members of the ACA provide advice to thousands of pension schemes, including most of the country's largest schemes. Members of the Association are all qualified actuaries and all actuarial advice given is subject to the Actuaries' Code. Advice given to clients is independent and impartial. ACA members include the scheme actuaries to schemes covering the majority of members of private sector defined benefit pension schemes.

The ACA is the representative body for UK consulting actuaries, whilst the Institute and Faculty of Actuaries is the professional body.

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