Attention: Mr Clint Oellermann **5 February 2015**
Inquiry Director
Health Market Inquiry
Email: submissions@healthinquiry.net

RESPONSE TO STATEMENTS OF INACCURACY OR MISLEADING INFORMATION OR ADVERSE ALLEGATIONS CONTAINED IN PUBLIC SUBMISSIONS

Introduction

Alexander Forbes Health (Pty) Ltd ("Alexander Forbes Health") is a wholly owned proprietary company of Alexander Forbes Financial Services Holdings (Pty) Ltd. Alexander Forbes Health is an authorised Financial Services Provider and licensed by the Financial Services Board (FSB) in terms of the Financial Advisory and Intermediary Services Act, 37 of 2002. The entity is accountable to two regulatory authorities in that it is also accredited with the Council for Medical Schemes (CMS) in terms of the Medical Schemes Act, 131 of 1998. As a leading corporate healthcare consultancy in South Africa**,** Alexander Forbes Health delivers healthcare consulting advice and member support services to over 600 corporate clients representing 190,000 families who are members of open medical schemes. Alexander Forbes Health also provides actuarial and technical consulting services to a number of restricted medical schemes.

Alexander Forbes Health welcomes the opportunity to respond to statements of inaccuracy or misleading information contained in various submissions in terms of paragraph 35 of the Statement of Issues, namely "whether the incentives of brokers and medical schemes, administrators, and/or other insurers are aligned with the interests of consumers."

The statements of inaccuracy or misleading information or adverse allegations are categorised per submission and highlighted in parenthesis with our corresponding response listed in standard font style below each statement.

1. **Board of Healthcare Funders of South Africa (FIN/BHF/02)**

1.1. "The rate of commission is 3% of contributions up to a maximum per month. This creates a perverse incentive for brokers to "sell" the most expensive benefit options to their clients so as to earn the maximum commission."

This statement is misleading. According to the Council for Medical Schemes (CMS) Annual Report 2013/14 broker commission in 2013 averaged R51.20 per average member per month (2012: R48.80pampm), a below inflation increase of 5.0% . This equates to only 1.8% of open medical scheme gross contribution income (GCI) in 2013. This figure is well below the maximum legislated commission of R71.07 per member per month and shows that brokers are not focused on selling only the most expensive options to maximise commission.

In addition, in terms of the Financial Advisory and Intermediary Services Act (FAIS) Act Code of Conduct healthcare brokers are required to base their financial advice on a thorough needs analysis of the client.

1.2. *"Medical schemes with low contributions (and often time's better benefits) are prejudiced by the commission structure set out in the MSA."*

This statement is inaccurate as illustrated by the growth in membership of KeyCare, Discovery Health Medical Scheme's range of lower income benefit plans. As per the CMS Anuual Report 2013/2014, consolidated membership of KeyCare plans stood at 232,865 principal members as at 31 December 2013. This growth has been almost exclusively driven by brokers. If KeyCare was a stand-alone scheme, it would be the third largest open medical scheme.

1.3. *"As things stand, every member of a medical scheme that has not appointed a broker is paying commission, from the risk pool of funds, to brokers that have been appointed by other members."*

This statement is inaccurate. Broker commission is only paid by a medical scheme in respect of those members who have appointed a broker. Where a broker is not apppointed, commission is retained in the scheme's gross contribution income. Regulation 28(5) to the Medical Schemes Act (MSA) requires that commission is paid monthly and only upon receipt of contributions in respect of that member. Furthermore Regulation 28(7) provides for a medical scheme to immediately terminate payment of commission upon notice from that member that the member no longer requires the services of a broker.

1.4. *"Brokers add significantly to the non-healthcare costs of medical scheme membership while the value and extent of the services they render to medical scheme members directly is questionable."*

This statement is inaccurate and misleading. According to the CMS Annual Report 2013/2014 broker commissions, a component of medical scheme non healthcare expenditure (NHE), equated to only 1.1% of industry GCI in 2013 (2012: 1.2%). Total NHE equated to 11.1% of GCI (2012:11.2%).

Regulation 28(1) to the MSA requires that a medical scheme enters into a written agreement with an accredited healthcare broker/s to provide very specific services. These services comprise of the introduction of new members and the provision of ongoing services and advice, as per Regulation 28(2). Furthermore, as per Regulation 28(6) the ongoing payment of commission by a medical scheme is conditional upon a broker continuing to meet the service levels outlined in the contract and failure to do so can result in immediate discontinuation of payment.

1.5. *"Brokers are usually paid by medical schemes rather than by the members they are supposed to be servicing. Many members do not even know that they have a broker or that they can approach the broker to assist them with advice concerning their membership."*

This statement is misleading. Regulation 28 to the MSA compels a medical scheme, and not a member to pay commission to a broker for the rendering of specific services as contracted. A separate negotiated fee can be paid by a member to a broker for additional services as agreed.

Furthermore as previously stated, commission is only payable per member and only where a member has appointed a broker. As per Regulation 28(7) if a member is dissatisfied with the services of a broker, such a member can terminate the broker's services and instruct the scheme to immediately discontinue payment of commission to the broker.

1.6. *"The table below shows how broker fees have increased between the year 2000 and 2012 in comparison to the relatively small increase in the number of lives covered by schemes."*

Year	***Lives***	***%***	***Broker Fees R(m)***	***%***
2000	*7 020 223*		*230*	
2012	*8 679 473*	*23.64%*	*1449*	*530%*

The information contained in this table is derived from the CMS Annual Report 2012 and is misleading as it does not allow for a transparent comparison or analysis of broker commissions.

The heading "Broker Fees R(m)" lumps broker commissions and all other distribution costs i.e. marketing and advertising costs together. These "additional" costs fall outside of regulated broker commission and distort the true fees paid to brokers.

2. Brian Watson (OTH/WATSON/10)

2.1. *"The current basis of remunerating brokers is entirely wrong and it creates a perverse incentive to brokers to favour the high cost medical schemes at the expense of their clients – all in order to achieve a higher commission payment for the broker."*

This statement is an adverse allegation. Please refer to our response in point 1.1.

2.2. *"An unusual situation exists whereby a prospective member consults a broker that is paid commission by the medical scheme and yet the medical scheme has no control or say over what medical scheme is recommended or punted by the broker."*

This statement is an adverse allegation. As mentioned in point 1.4 the services rendered by a broker are set down in a written agreement with the medical scheme and payment of commission is conditional upon the broker meeting the service levels outlined in the agreement.

2.3. *"It is not uncommon for administration companies to find ways to remunerate brokers, in addition to the legal level of commission set out in regulation 28 to the MSA, for soliciting new members. The most common method used is marketing fees. Marketing fees are a ploy used by some administration companies and medical schemes to remunerate brokers beyond the limits prescribed by law. Each of the ploys used add a layer of cost to the medical scheme with no added value effectively driving up the cost of medical scheme membership."*

This statement is misleading. Broker conduct is regulated by the MSA and the FAIS Act. The Registrar of Medical Schemes is empowered by regulation to investigate allegations of misconduct on the part of brokers, administrators and trustees and to take appropriate action. Regulation 28C provides for the suspension or withdrawal of broker accreditation where evidence of misconduct is presented. An example of intervention by the Regulator is the placement of Medshield Medical Scheme under curatorship in October 2012, in part for the illegal payment of fees to certain brokers.

3. Medscheme (FIN/Medscheme/11)

3.1 *"The distortion in broker commission between medical schemes and other insurance markets in South Africa may encourage perverse incentives. To encourage brokers to sell their medical scheme, medical schemes have over the years devised insidious methods to try and reimburse brokers more than allowed by the Regulations. Similarly, insurance companies have co-branded medical schemes under the same name to encourage cross-selling of insurance products together with the medical scheme membership, thereby paying the broker more."*

This statement is misleading. As financial consultants, healthcare brokers are required in terms of the FAIS Act Code of Conduct and the Treating Customers Fairly (TCF) initiative currently under implementation by the Financial Services Board (FSB), to conduct a financial needs analysis for each client to identify funding gaps and to recommend the most appropriate product solution to meet a client's needs. This may very well include a combination of medical scheme cover and health insurance.

4. Profmed (FIN/PROFMED/18)

4.1 *"It is submitted that an unintended consequence of the restriction imposed on broker fees has resulted in ancillary and various other products (i.e. loyalty programmes) and often inferior products (i.e. certain health insurance products) in respect of which commission is unregulated, being sold to unsuspecting consumers to enhance the income of brokers. The interests of consumers could therefore be secondary to those of brokers when products are sold."*

This statement is misleading. As mentioned in point 3.1 above, accredited healthcare brokers are legally entitled to sell both medical scheme and health insurance products (if they are duly licensed to do so). In fact, healthcare brokers have a legal obligation under the FAIS Act Code of Conduct to recommend any combination of financial products that will meet a client's needs. Whilst the sale of loyalty type products is unregulated, health insurance products are regulated by the Short-Term and Long-Term Insurance Acts, as is the maximum commission payable on these products (maximum commision of 20% of the premium payable for short-term insurance products).

To state that consumers are unsuspecting of the products being sold to them is mere speculation. If this were true, one would expect a large number of consumer complaints lodged with the CMS, which is not in evidence. According to the CMS Annual Report 2013/2014, a total of 5,473 complaints were lodged in 2013 (2012: 5,253) of which 14 (2012: 3) related to broker services (incorrect advice and broker conduct).

5. Cape Medical Plan (FIN/CMP/54)

5.1. *"Intermediaries base their advice on the personal incentive of the Intermediary's chance of commission, rather than on fundamental principles."*

This statement is an adverse allegation. Please refer to our response in point 3.1. The FAIS Act Code of Conduct and the FSB's TCF initaitive ensure that advice is based on an understanding of a client's needs.

5.2. *"Once members are on their database, intermediaries will "churn" members to other schemes where commission is more attractive."*

This statement is an adverse allegation. In terms of Regulation 28(2) to the MSA, the rate of broker commission is regulated up to a maxmum amount, currently R71.07 per member per month plus VAT, and a medical scheme is not restricted from applying a sliding scale to this amount. There is therefore very little, if any incentive for brokers to switch members between medical schemes on the basis of higher commission.

5.3. *"Commission paid to intermediaries create additional administration expenditure without any value contribution because it is paid by the whole scheme and not the individual using the intermediaries services."*

This statement is inaccurate. Please refer to our response in point 1.3 and 1.4.

6. South African Medical Association (PRA/SAM/61)

6.1. *"Medical schemes use brokers to attract members, not by enrolling previously uninsured members, but by poaching members from other medical schemes. This is achieved by promoting non-healthcare related benefits"*

This statement is an adverse allegation. Open medical scheme membership, where growth is largely driven by brokers, has grown by 27.4% (484,651 principal members) in the 14 year period from 2000 to 2013. This growth in membership has occurred in a highly regulated and complex environment with high barriers to entry for consumers and significant information asymmentary.

The role of a broker is to act in the member's best interest and to continuously seek out value for the member. This activity promotes competition between medical schemes and administrators to offer value propositions to both new and existing members.

This response is compiled by Technical and Actuarial Consulting Solutions (TACS), a division of Alexander Forbes Health (Pty) Ltd. Enquiries can be directed to:

Butsi Tladi
Manager Director
Tel: 011 269 0340
Email: tladib@aforbes.co.za

Anthea Towert
Tel: 011 269 0507
Email: towerta@aforbes.co.za