2018

Consolidated Comment on Draft Medical Schemes Amendment Bill:

Executive summary

1. **Dual regulation not conducive to maximum client protection. FSCA should regulate market conduct.** Classique Medical Aid consultants CC supports the Financial Advisory and Intermediary Services ("FAIS") Act as the most appropriate regulatory framework for managing possible conflicts of interest in the provision of independent advice to consumers. The dual regulatory framework creates a regulatory arbitrage not conducive to maximum consumer protection. We believe that the current Independent Intermediary model is a sophisticated model that was recognised as not being a cost driver of private medical scheme costs. Whilst we, however, recognise that the current model may not be perfect, it does not give rise to major systemic concerns. Classique Medical Aid Consultants CC recognises that the conflict of interest debate is not restricted to the private medical scheme environment but is also part of a larger strategic thought process within the Financial Services Regulatory Framework. In this regard we strongly recommend that medical scheme advisory and intermediary services be aligned to "workflow 2", the Retail Distribution Review (RDR) with specific reference to Equivalence of Reward and Intermediary Categorization for the broader financial services discussion, as lead by National Treasury.

2. **The Medical Scheme Amendment Bill should be temporary withdrawn.** Classique Medical Aid consultants CC believes the proposed amendments to the Medical Schemes Amendment Bill should be withdrawn until such stage as the Health Market Inquiry have published its final report. This will allow the Minister of Health to include the final recommendations of the Health Market Inquiry in any proposed new legislation.

3. **The Independent Healthcare advisor adds value to the industry and consumers.** Classique Medical Aid Consultants CC have submitted evidence of the value that Independent Healthcare Intermediaries add to the private medical scheme industry and specifically the members of medical schemes. Our opinion is supported by the fact that more medical scheme members now make use of the services of Independent Healthcare Intermediaries than before. We have also provided evidence that Independent Healthcare Intermediaries are only servicing the interest of their clients, the members of medical schemes. This value is rendered without being a cost driver of private medical schemes. We are also humbled by the recognition of the Independent Healthcare Intermediaries value and role as identified by the Health Market Inquiry.

4. **The current opt-in and opt-out system offer maximum consumer protection.** Classique Medical Aid Consultants CC recognises that no regulatory framework can be perfect. The current model, however, although not perfect, does not necessarily require major structural changes. Further, Classique Medical Aid Consultants CC believes that any change to the regulatory framework should have been proved to be necessary, and any change should be based on ensuring a fairer treatment of the consumer - based on cost benefit analysis as well as impact analysis. The current framework requires an explicit opt-in or appointment by the member or the employer on behalf of its employees of the intermediary and should there be no further need for the intermediaries services the service can be immediately terminated and medical schemes must comply with the instruction. Further, members can also join medical schemes and interact with medical schemes without an intermediary. This system is efficient and should be retained. The current system can be improved by adding the intermediary's information to all correspondence of medical schemes with members.

5. **Discounted contribution tables will harm consumers.** The current practice to allow members to join and interact with medical schemes without an intermediary attract criticism that in such cases consumers should receive a discount. Classique Medical Aid Consultants CC believes a discount for the non-use of an intermediary would not serve the interest of members for the following reasons:

a. Not using an intermediary does not come at no cost to the private medical scheme system. Medical schemes provided evidence to the HMI that where intermediaries are not used ("Orphan policies") that the cost relating to administering those members are higher than where intermediaries are used.

b. An unintended consequence of a discounted model will be that members can select to appoint an intermediary when services are needed and terminate the appointment when services were received. The only protection for intermediaries is to move to a fee-based system where intermediaries do not benefit or operate in a community rated service and commission environment. This will exclude more than 60% of members from financial advice due to affordability.

c. A discounted model will create a *countervailing power* where medical schemes and their tied agents will be in direct competition with their distribution channel, the Independent Healthcare Intermediary. This *countervailing power* will create an anti-competitive landscape only benefitting medical schemes and benefitting larger medical schemes more than smaller medical schemes.

d. The theory of harm is not an exact science nor easy. Even if consumer harm can be measured accurately, the trading of gains in profits is even more challenging.[1]

e. The current system where Independent Healthcare Advisors are used creates no dualistic or competing or countervailing power. Therefore, an Independent Healthcare Advisor must convince existing clients or prospective clients that its services are superior to that of other Independent Healthcare Advisors. Price won't play a role because commission is standardised, only value demonstrated will be a deciding factor. In addition, the Independent Healthcare Advisor, to earn commission must demonstrate value to existing or prospective clients to the extent that making use of the services of an Independent Healthcare Advisor is more valuable than going directly to a medical scheme. Price won't play a role because commission is standardised and paid if using an Independent Healthcare Advisor or not, only value demonstrated will be a deciding factor. Consumer harm is reduced by standardising and community rating commission.

f. If the consumer will be afforded a discount if making use of tied agents or going directly to a medical scheme, such a policy will lead to exclusionary practices. Based on price the commission-based services of Independent Healthcare Intermediary will be excluded effects[2]. A particularly difficult area is exclusionary pricing. Competition policy seeks to protect competition and thereby, inter alia, to deliver lower prices to consumers. However, sometimes lower prices lead to harmful exclusionary outcomes where, for example, they deliver a very good deal to (a certain group of) consumers in the short term but substantially reducing competition in the long term and creating more harm than the benefits of reducing price. A discounted commission model will eventually lead to a fee-based service model where, contrary to the current system, most members will not be able to afford fee-based services.

g. A simplistic way of addressing consumer harm is to argue that the existing system is more expensive and that a discounted model will lead to consumer benefits due to the cost saving. At best this line of argument will just defer the same question of consumer harm to a later stage. Exclusionary practices itself is a harm to consumers[3]. In practical sense more than 90% of members make use of the services of an Independent Financial Advisor. This is for the consumer (family) on average R 65 pm but can be as little as R 11,10 and maximum R 90. This gives the consumer access to unlimited advice and intermediary services as defined by the FAIS General Code of Conduct[4]. However, in a fee-based model of say R 750 per hour a family will be able to

1 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 145

2 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

3 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

4 FAIS General Code of Conduct

buy less than 6 minutes of an Independent Healthcare Advisors time with the saving achieved. Alternatively, only one-third of members will be able to afford the services of the Independent Healthcare Intermediary. The loss to the consumer far exceeds the possible gain of a mere, on average R65 pm saving.

6. **The current commission model is preferred by consumers.** Classique Medical Aid Consultants CC is concerned about direct or indirect increases in non-healthcare expenditure. In this regard we believe that consumer research indicates that employers and employees are not prepared to pay additional fees. Since the research was conducted, the economic climate has worsened emphasising Classique Medical Aid Consultants CC's objection to cost increases. Classique Medical Aid consultants Cc also strongly believes that the community rated model pertaining to broker remuneration ensures that consumers are guaranteed access to advice. This moral hazard should be avoided at all cost as the proposed model will seriously jeopardise the poor's access to independent advice. Classique Medical Aid consultants Cc strongly cautions that this may be the unintended consequence of the proposals contained in the discussion document.

7. **The Independent Healthcare Advisory model can be improved, and the industry can further be professionalised to the benefit of the consumer**. Classique Medical Aid consultants Cc identified specific shortcomings in the current regulatory framework and suggests the following possible solutions:

    a. Development of Model contracts. However, the model contract should not substitute or duplicate market conduct oversight of the FSCA;

    b. Using Undesirable Business Practices Regulation / Legislation to deal with breaches of market conduct;

    c. Establishing an Undesirable Business Practices Hotline;

    d. Publication of disputes;

    e. More forceful enforcement by using the current regulatory tools;

    f. Statutory apprenticeships;

    g. Minimum Qualification;

    h. Inflation linked increases.

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Representativeness of Classique Medical Aid Consultants CC

Classique Medical Aid Consultants CC consist of the following organisations:

- Financial Intermediaries Association, and
- Financial Planning Institute of Southern Africa, and
- Financial Services Intermediary Network.

Together these associations represent approximately 6 000 intermediaries who render Financial Advisory and Intermediary services to an estimated 70% of the private medical scheme market.

The Independent Healthcare Adviser and the Legislator

The Independent Healthcare Intermediaries continuously interacted with the regulator and legislator to further improve the private healthcare landscape.

AHABA submission to the Portfolio Committee on Finance 2 October 2001

The submission if the Association of Health Benefit Advisors (AHBA)[5] was made on behalf of approximately 6000 Independent Healthcare Advisors. AHBA provided evidence to the portfolio committee on finance that healthcare advice is internationally regarded as financial advice and as such Independent Healthcare Advisors should fall within the scope of the FAIS Act. At that stage Independent Healthcare Advisors were excluded from the FAIS Act. This motion of AHABA to the portfolio committee on finance was accepted and the advice portion or market conduct of Independent Healthcare Advisors were then placed back under the ambit of the FAIS Act.

AHABA provided the following financial planning example to the Portfolio Committee on Finance[6]:

- "**A case study that illustrates that health care advice forms part of financial advice**

  Mr. J, a very healthy 30 years old, just married with a newly born baby asks Mr. P an accredited health care broker and certified financial planner to draw up a comprehensive financial plan. Mr. J's previous financial needs in order of importance were:

  ☐ Short term insurance
  ☐ Short term savings
  ☐ Investment plan
  ☐ Medical scheme
  ☐ Life cover
  ☐ Disability
  ☐ Retirement

  After a comprehensive needs analysis and current provisions it was discovered that his priorities should change as follows:

  ☐ Increase disability cover dramatically;
  ☐ Improve retirement provision to maximise tax benefits;

5 Hansard 2 October 2001

6 Hansard 2 October 2001

☐ Increase life cover marginally;
☐ Reduce short term insurance;
☐ Reduce short-term savings due to the tax deduction being exceeded;
☐ Retaining investment portfolio constant but invest portfolio more aggressively; and
☐ Reduce medical scheme to a less comprehensive medical scheme or option.

These proposed amendments to Mr. J's portfolio were clearly explained with full disclosure of the impact it will have on his family's risks.

A few months later he was hospitalised due to an accident and suffered complications. His expenses were R50 000 more than his medical scheme limit.

He is upset and wants to seek recourse for bad advice, to who will the complaint be lodged? (The FSB or the Council?)

Should Mr. J complain to the Council, it might be decided that the advice was inappropriate (only investigating singular product advice). Should Mr. J complain to the FSB, it might be decided that the advice was totally appropriate (investigating a comprehensive financial need analysis).

The only regulator able to analyse a comprehensive needs analysis, and consequently the financial advice, would be the FSB. The public and all industry related associations accepted this principle."

FPI submission to the Portfolio Committee on Health 20 September 2002

The submission if the Financial Planning Institute of Southern Africa (FPI) [7]was also supported by The Independent Broker Council, Life Underwriters Association of Southern Africa and the South African Healthcare Intermediary Association. Together these organisations represented 6 000 Independent Healthcare Advisors providing advice to most members on open medical schemes.

The FPI warned against the unintended consequence of trade unions or employer groups that can be remunerated for broker services without being recognised as brokers. It is encouraging to see that after 16 years the Minister want to change this unintended consequence.

The FPI motioned for ongoing commission to be paid and this motion was adopted in the regulations as proposed. However, the FPI suggested that trustees should exercise due consideration with whom they want to contract and who not. Sadly, in the last 16 years trustees have not managed the contracts with Independent Healthcare Advisors properly. There remains huge scope for improvement.

The FPI presented their arguments to the portfolio committee on health that differentiated rate tables should not be allowed. This was accepted.

CMS appearing before the Portfolio Committee on Health 17 November 2009

The CMS appeared before the Portfolio Committee on Health on 17 November 2000[8]. The CMS presented their 2008/09 annual report to the Portfolio Committee on Health. No reference was made to brokers.

7 Hansard 20 September 2002

8 Hansard 17 November 2009

CMS appearing before the Portfolio Committee on Health 13 October 2010

The CMS appeared before the Portfolio Committee on Health on 13 October 2010[9]. The CMS presented their 2009/10 annual report to the Portfolio Committee on Health. Broker commission was mentioned but the Registrar remarked that there is no correlation between commission and membership increases. This is due to two reasons. Firstly, commission is paid for placing a member with a medical scheme and providing ongoing services. Secondly the growth in commission is primarily driven by more members making use of the service of an Independent Healthcare Advisor.

CMS appearing before the Portfolio Committee on Health 11 October 2011

The CMS appeared before the Portfolio Committee on Health on 11 October 2011[10]. The CMS presented their 2011/12 annual report to the Portfolio Committee on Health. **Commission was incorrectly quoted as R1,4 billion. This figure includes marketing and distribution costs.** It is interesting to note that the chairperson commented that brokers must make members in rural areas aware of the functions of the CMS. This is a marketing function of the regulator imposed on the Independent Healthcare Intermediary. The chairperson of the portfolio committee on health was not mistaken. However, this duty falls outside the scope of broker services as defined in the Medical Schemes Act or the FAIS Act. It is these additional and regulatory scope creep that Bamber and Falkena [11] refers to that have no commercial value and is perceived by consumers as a free service. This is another example of the complexity of the services of the Independent Healthcare Intermediary and the difficulty to identify all the beneficiaries of the service of the Independent Healthcare Intermediary and to bill those entities for the service of the Independent Healthcare Intermediary.

BUSA and FPI appearing before the Portfolio Committee on Health 15 March 2012

The Business Unity South Africa and the FPI appeared before the Portfolio Committee on Health on 15 March 2012[12]. The purpose was to give comment on the Health Amendment Bill and specifically the OHSC and the Office of the Ombud. In this BUSA and the FPI also motioned for a health compact between Government, Business, Organised Labour and Civil Society. Whilst FPI represent the interest of the Independent Healthcare intermediary they rose above this narrow role to support the national health debate and finding solutions that benefit all citizens.

CMS appearing before the Portfolio Committee on Health 30 July 2014

The CMS appeared before the Portfolio Committee on Health on 30 July 2014[13]. During the CMS presentation the CMS referred to some medical schemes that refused to accept Transnet pensioners. This case is known as an appeal board case and is referred to as Jacobs vs Discovery. Jacobs is an Independent Healthcare Intermediary who represented a Transnet pensioner against a decision of Discovery medical scheme. This case was successfully prosecuted by Jacobs making use of Werksmans attorneys and employing Senior Council up to Appeal Council lever. After Jacobs left the employment of his employer the employer's legal team successfully prosecuted the matter at Appeal Board level. The prosecution at appeal board level was in support of the CMS

9 Hansard 13 October 2010

10 Hansard 11 October 2011

11 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

12 Hansard 15 March 2012

13 Hansard 30 July 2014

and the Appeal Council decision. This was done at no cost to the pensioner. This is an example demonstrating that the Independent Healthcare Intermediary is in service towards its clients and not beholden to the medical scheme who paid millions to the company who employed Jacobs[14].

A brief discussion was held on the contract that exist between the member and the Independent Healthcare Advisor and that payment should be direct between the member and the Independent Healthcare Advisor. This discussion did not follow the order of discussions and no real information to support the statements were provided. This statement also fails to appreciate the reasons why the decision was taken deliberately to remunerate the Independent Healthcare Advisor from commission on the medical scheme contribution.

FIA appearing before the Health Market Inquiry

The presentation of the (Financial Intermediaries Association (FIA) to the Health Market Inquiry (HMI) on 3 March 2016 were based on three pillars namely[15]: Firstly, why there is a need for broker services? Secondly, how are brokers remunerated. Thirdly, other regulatory issues for consideration such as the dual regulation of brokers by the Financial Serviced Conduct Authority (FSCA), the Retail Distribution Review process (RDR), and the Council for Medical Schemes (CMS).

The FIA representation mentioned that the FIA work tirelessly to improve the perception of intermediaries and promote the value of financial advice[16]. Statements like this is often misunderstood as though the image of intermediaries are poor[17]. However, the financial services advisory sector as a relatively young profession compared to medical practitioners, the legal profession and accountants will require constant improvement. Aspects that the FIA motioned for is education levels and continued education to be implemented. These actions improve the image of Independent Healthcare Intermediaries. The second part of what FIA does is to promote the value of Financial advice. It is common course that financial literacy is very low. Making consumers aware of the value of financial advice also builds the image of Independent Healthcare Intermediaries. This task is not complete and a future focus on these two areas are plausible and needed.

Me Tladi of FIA explained the complexity of the healthcare landscape that Independent Healthcare Intermediaries must navigate their clients through. In this she also explained that Independent Healthcare Intermediaries develop tools, skills and apply knowledge to assist their clients[18].

Me Tladi of FIA also emphasised the complexity of the dual regulatory environment in which the Independent Healthcare Intermediaries must manage their services. In addition, Me Tladi also addressed the cost implication of dual regulation as well as the inefficiencies and confusion that this dual regulation brings. We expand further on this dual regulation in our written submission.

Role of the independent healthcare adviser

In most cases, of the consumer portfolio of policies, medical scheme cover will be the most expensive and complex “insurance” purchase, necessary to protect assets, health, and the well-being of the members and his family. Suffice to say, that it is critical that the consumer is given the benefit of making an informed and appropriate decision. Notwithstanding the obvious interests of the consumer, the entire industry is a critical

14 http://www.medicalschemes.com/files/Judgements%20on%20Appeals/DiscoveryVsRegistrarNJ2012.pdf

15 HMI Transcript 3 March 2016, p199

16 HMI Transcript 3 March 2016, p201

17 HMI Transcript 3 March 2016, p232

18 HMI Transcript 3 March 2016, p204-205

stakeholder, dependent on the fact that the member has purchased sufficient and appropriate cover, in the first instance.

Even though many initiatives have been instituted at both Government and medical schemes level alike, indications are that the membership base has grown a paltry amount, indicating that members still consider medical scheme membership as an expensive "grudge purchase". Without the selling skills of the independent advisor industry, in both selling and maintaining the current membership level, there are no indications that administrators or medical schemes can single-handedly manage the product marketing and member retention, required at this very high level.

The reality of the situation, however, is that professional independent advisors in this highly specialized field are hard pressed to make ends meet, given the legislation applicable to the payment of commission by medical schemes. Moreover, medical schemes advise that many highly effective independent healthcare advisors are simply leaving the industry to embark on alternative projects. Independent healthcare advisors provide many services to consumers that ensure that consumers can make informed decisions[19]. The consumer pays the independent healthcare adviser in the form of commission calculated on a community rated principle. The medical scheme merely acts as a conduit for payment of the commission where the consumer opted in.

Essentially these services fall within two broad categories, i.e. to advise and protect the medical scheme member.

Advise the medical scheme member on:

The advice provided by the independent healthcare advisor is not a once off event but a continuous process[20]. The key areas of continuous advice[21] provided is listed below:

- which medical scheme to select[22],
- members rights when changing schemes,
- the consequences of changing schemes,
- the details and procedures applicable to their new scheme (education),
- annual option changes,
- changes in legislation and the impact thereof,
- changes to the benefit structures and/or the procedures applicable to their medical scheme and the impact thereof,
- Giving on-going feedback on the financial and administrative stability of members chosen scheme.

However, before advisory or intermediary services can be rendered an Independent Healthcare Advisor must in terms of the FAIS General Code of Conduct:

- **Keep proper records:** The FAIS General Code of Conduct place huge emphasis on recordkeeping. The following sections of the FAIS General Code of Conduct[23] are relevant: Paragraphs; 3(2) (a), (i), (ii) and (iii), 3 (2) (b),(c) and (d), Par 8, Par 9 (1) (a), (b), (c) and (2)
- **Must render proper needs-based advice:** Par 1, 2 and par 8 of the FAIS General Code of Conduct [24]deals with advice provided. Par 1 deals with the requirement that advice must be factually correct and that specific aspects should be disclosed to the client. Par 2 encapsulates the ethos of the FAIS General Code of Conduct. It states as follows: "A provider must at all times render financial services honestly, fairly, with due skill, care and diligence, and in the interests of clients and the integrity of the financial services industry." Par 8 deals with the steps of providing suitable advice.

19 HMI preliminary report 5 July 2018, p461, par 54

20 HMI preliminary report 5 July 2018, p37 par24

21 HMI preliminary report 5 July 2018, p58 par135

22 HMI preliminary report 5 July 2018, p115

23 FAIS General Code of Conduct, par 3,8 & 9

24 FAIS General Code of Conduct, par 1,2& 8

- **Disclosure:** The FAIS General Code of Conduct in par 3 require detail to be disclosed regarding the Financial Service provider rendering the service and the contracting party. This would include complaints procedures[25]. Par 7 of the FAIS General Code of Conduct compel the Intermediary to disclose detailed product information as well as the implications of the products or change to products[26]. Par 8 of the FAIS General Code of Conduct compel the Intermediary to disclose the contribution all fee and commission[27]. Par 9 of the FAIS General Code of Conduct compel the Intermediary to provide the client with a record of advice[28].
- **Be properly qualified and undergo continued professional development[29]:** Independent Healthcare Advisors must in terms of Board Notice 194 issued by the FSCA relating to the Fit and Proper Regs with specific reference to product accreditation (training) complete the Class of Business training (classes 1 and 9 for healthcare intermediaries) and will also have to complete the product accreditation training. This is in addition to the regulatory exams, minimum education levels and experience requirements.

The areas of advice will be unpacked below.

Which medical scheme to select – benchmarking

An Intermediary or Independent Healthcare Advisor has a vital role in assessing the needs of a prospective member and structuring an appropriate plan for members of an employer group or an individual member. There are a significant number of medical schemes to choose from, and each of these has several benefit options, which complicates the selection process for a member without the support of an informed and experienced professional.

Medical schemes and administrators cannot be expected to supply independent information on how their products compare to their competitors, and which of their options would be most suitable to the health needs of the member. At the end of the day, the uninformed, or misinformed member would be heavily influenced by the marketing and sales approach of the medical scheme and its administrator. Those with the best marketing campaigns and the greater financial resources would attract the interest of the most members looking for healthcare cover. This will be unfair to consumers.

This is particularly relevant to the individual member and small groups where they do not have the benefit of a corporate human resources service to spend the time analysing and investigating medical scheme options. In any event, all medical schemes will tell you they have the best solution for you and will not voluntary disclose any of their problem areas or shortfalls. This is where the Independent Healthcare Advisor adds value as they have clients across a broad range of medical schemes and will be able to identify these issues and advise members accordingly.

Independent Healthcare Advisors can assist in forming Steering Committees, with large employer groups. These committees are elected and are responsible for taking the decisions in respect of medical cover. The Independent Healthcare Advisor will educate the members of the committee to ensure that they are well informed in terms of the decisions that they are entrusted to make. The decision taken by the committee is then more likely to be made objectively and prohibits individual prejudice creeping into the decision-making process which could ultimately be prejudicial for the greater number of employees. It also discourages medical schemes from offering financial incentives to individuals to place the business with them. The Independent Healthcare Advisor is therefore able to ensure that decisions are taken in the interests of members, and not in the interests of financially motivated individuals.

25 FAIS General Code of Conduct, par 3

26 FAIS General Code of Conduct, par 7

27 FAIS General Code of Conduct, par 8

28 FAIS General Code of Conduct, par 9

29 Board Notice 194 issued by the FSCA

Member rights when changing schemes

The legislation governing the medical scheme environment is complex and medical schemes often abuse the fact that most members do not understand their rights. Although legislation has been designed to ensure access for all members there are still some provisions which allow medical schemes to protect themselves, specifically where waiting periods and late joiner penalties are concerned.[30]

Independent Healthcare Advisors have, however, encountered several cases where medical schemes have used these protection mechanisms incorrectly, not to protect themselves from adverse member behaviour, but to discourage poor risk members from joining their medical schemes. Once again, the individual member and small groups are particularly at risk as larger groups usually obtain favourable group underwriting status where waiting periods and late joiner penalties are not applied.

The consequences of changing medical scheme membership

The prohibitive cost of medical scheme cover increases members' focus on trying to find alternatives where they can save on monthly contributions during the year. Interim increases implemented by medical schemes, as well as the restriction most medical schemes impose on members where they may change options only once a year, compounds this problem. There are however many important issues members need to consider when they decide to change medical schemes during a calendar year and these are often overlooked with dire consequences to the medical scheme member[31].

Some examples are:

- Savings account claw backs. Members who have spent their full annual allocation (in cases where this is advanced to them in January) will have to repay the proportion relating to the balance of the year when they leave the medical scheme.
- Pro-rated benefits. Joining a new medical scheme part way through the year will mean that members only have access to a pro-rated portion of the benefits offered by the new medical scheme. This can have dire consequences, specifically where hospital benefits are limited or where the new medical scheme has an overall limit.
- Focusing on cost savings and not on the benefit reductions that may accompany these cost savings may leave members at risk.
- Not considering changes in any specialised benefits. Members changing schemes with specific medical conditions (cancer, chronic medication benefits, HIV/AIDS etc) might not properly evaluate the level of benefit on the new scheme for these specific conditions. This is specifically, true in group situations where centralised decisions are made without giving due consideration to the detail.

The above issues may seem obvious but are often lost in the heat of the moment where aggressive medical scheme marketing, the issues with the current medical scheme (administrative or cost), and the prospect of contribution savings are the immediate consideration. Independent Healthcare Advisors ensure that members are advised of these issues and other risk indicators and keep them in mind while evaluating their decision to change medical schemes.

Member education

Independent Healthcare Advisors play an important role in educating members. Although, medical schemes issue members with a hand-book, these documents are often complex and confusing to members, and very few members take the time to do the research required to become informed of their benefits, and how to comply with administrative requirements in the management of their medical benefits. Some of the areas that Healthcare Advisors focus on include, but are not limited to:

30 FAIS General Code of Conduct par 7 (1) (a) and (b) and (c)(vii) and (Viii) and (x) and (xiv)

31 FAIS General Code of Conduct par 7 (1) (c)(vii) and (Viii) and (x) and (xiv)

- Procedures to follow: - e.g.
  - Hospital pre-certification, and the penalties associated,
  - Chronic medication applications,
  - Generic versus ethical medication cover,
- Procedures to follow in the case where exceptions need to be made relating to protocols, formularies or any other managed care initiatives.

Many medical schemes do not cover these aspects adequately in their marketing brochures / handbooks. It is normally the Independent Healthcare Advisor that spends time with individuals, or in group sessions educating them about the benefits, requirements and potential pitfalls of the members' chosen medical scheme about all the above issues. In many instances, without the assistance from the Independent Healthcare Advisor, members would be faced with penalties in respect of not adhering to hospital pre-certification procedures and non-compliance with the rules of the medical scheme.

Chronic applications are also repeatedly lost by medical schemes, often at the risk of compounding a member's chronic condition. Independent Healthcare Advisors can facilitate the quick processing and approval of chronic applications, which would otherwise lead to potential hospital bills because of members being left without their requisite medication. Again regrettably, members are often overwhelmed by the administrative procedures required by medical schemes to get their chronic medication approved and are reliant on Independent Healthcare Advisors to assist them with this function.

Independent Healthcare Advisors fulfil a valuable role with regards to members by ascertaining what their healthcare requirements are and ensuring that they choose the most appropriate cover. In addition, Independent Healthcare Advisors can assist members in educating them as to which benefits they qualify for, how to claim those benefits, and where they can maintain and preserve their benefits through negotiation with providers. In an employer group there will most likely be employees covered under conventional private medical schemes as well as on the low-income medical schemes. It is unavoidable that the education needs of both classes of employees will need to be addressed. Specific attention would need to be given to:
The reasons for this dualistic system of coverage and the demarcation between them.
Education needs of the previously uncovered employees to facilitate understanding of how to access their benefits.

The FAIS General Code of Conduct is concerned about advisory and intermediary services. Member education is not a requirement imposed on representatives in terms of the FAIS Act or General Code of Conduct. Independent Healthcare Advisors, as responsible stakeholders, voluntary render member education services to reduce the asymmetry of information between the member and the medical scheme. The legislator, the regulator and the HMI is appreciative of these educational services rendered by Independent Healthcare Advisors. However, consumers and regulators as stipulated by Bamber and Falkena will not be prepared to pay a fee for these perceived free services. It is for this specific reason that a non-discounted community rated commission model exists[32].

Annual Option Changes

Most medical schemes only allow members to change options once a year and this is the only opportunity a member gets to ensure that they are on the correct health plan to suit their health care and financial needs. Medical schemes, however, generally do not provide much information to members over this time to assist them in understanding the other options offered by their chosen scheme. Those few that do provide reasonable information to members often end up confusing the member to such an extent that the task of evaluating other options becomes prohibitive and members end up remaining on the same option they belonged to previously. This was confirmed by the fair treatment project.

There are several reasons why medical schemes often do not supply members with adequate information with two of the most prominent being:

32 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

- the cost associated with sending detailed information to members (postage and printing). This is further compounded by the fact that at the time the medical scheme communicates the changes in benefits and contributions the amendment to the rules of the medical scheme has not been registered yet, and any changes imposed by the Registrar of Medical Schemes will lead to additional costs, and
- the desire to keep members on the same options and avoid them buying down to lower cost options as this can impact on reserve growth and administration fee income.

In 2003 one medical scheme was planning to advise members of the cost increases to their current option only and not provide any information on the other plans offered by the medical scheme. Many similar examples exist. This is clearly to the disadvantage of the member as there is no way for the member to evaluate whether any other options would better suit the member's needs.

Independent Healthcare Advisors also add a lot of value by proactively assisting the member to evaluate the option they are on, based on their utilisation of benefits. A specific example is that of a member on a savings-based plan which offers an above-threshold benefit. There is no point for that member to remain on that option if he never benefits from the above threshold benefit, and in addition, has accumulated savings more than R10 000. These cases are common with members who do not realise this, nor do they take the time to understand the options on offer that may provide them with better value for money. However, there is no incentive for the medical scheme to advise the member about a possible reduction in benefits as that will mean less profitable risk contributions. The administrator on the other hand may also benefit from the higher contributions, (where administration costs are a percentage of contribution), and therefore it will be to the administrator's advantage to withhold the information from the member. The removal of flexible savings accounts created automatic self-payment gaps which increased the need for more individualised advice. It is also in the best interest of the member to be aware of developments within other medical schemes over this period so that they can compare their current scheme against others and ensure that it is being properly managed.

The Independent Healthcare Advisor fulfils a very real and valuable role to medical scheme members over this time. Members on the incorrect option become disillusioned by the concept of value offered by their medical scheme and then look to either opting out of medical scheme cover or changing part way through the year which has significant consequences as set out above.

Changes in legislation and the impact thereof

Independent Healthcare Advisors make sure members are notified of these changes –medical schemes will not volunteer information which is in the members' interest, and to their detriment etc.

An excellent example is the window period applicable for employer groups choosing to move medical schemes at the beginning of a benefit year, provided they have given the medical scheme the 90 days' notice of their intention to join the medical scheme. In this instance the medical scheme may not underwrite the group. This information has not been made widely known by medical schemes, and it is the Independent Healthcare Advisors' role to ensure that members are informed of this and to ensure that the requisite paperwork is completed timeously to ensure that employer groups can move medical schemes without attracting underwriting.

Another example is the changes to chronic benefits from 2004. Several organisations including the Financial Planning Institute (FPI), the Insurance Brokers' Council (IBC) and the South African Healthcare Intermediary Association (SAHIA) have expressed concern about the way new rules relating to chronic benefits are treated by most medical schemes. A joint committee then prepared and submitted a report in this regard to the Council for Medical Schemes. The Council for Medical Schemes responded that it was in precisely this sort of area where the Council believed Health Care Intermediaries could play a role in educating the consumer. The Council encourages the FPI and the other organisations represented to alert their members to the issues as highlighted in the report so that clients could be advised accordingly. These services are deemed as a free service and no commercial value can be attached to it as explained by Bamber and Falkena[33].

33 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

This submission, and previous submissions to the Portfolio committee on Health and Portfolio committee of Finance elevated the role of the Independent Healthcare Advisor from merely protecting their remuneration to addressing the needs of the consumer. Consumers (Members and employers) expect their Intermediary to explain legislation, current and future, and to make representation to parliament and the regulator on their behalf. However, this consumer advocacy role that the Independent Healthcare Advisor fulfils is seen as a free service to which no commercial value can be attached as explained by Bamber and Falkena[34].

Changes to the benefit structures and/or the procedures applicable to their medical scheme and the impact thereof

Again, Independent Healthcare Advisors offer this service to members, where medical schemes are slow to disseminate such information. Very often chronic disease coverage is altered, and previously covered conditions are removed from an approved list within a medical scheme. This information is not disseminated timeously to members to enable them to make an informed decision of whether they want to continue with their existing option or move to an alternative with better chronic benefits. Independent Healthcare Advisors ensure that they are up to date on all such changes and are proactive in informing members of such changes, which enables the consumer to make informed decisions in terms of their healthcare coverage.

Ongoing feedback on the financial and administrative stability of their chosen medical scheme

No medical scheme will admit to falling solvency ratios and financial pressures, which could translate into higher than average increases for members. Independent Healthcare Advisors can keep members informed of the financial stability of schemes, and very often are able to warn members in advance of what to expect from a medical scheme that is under financial pressure.

Medical Schemes are also slow to admit to administrative problems. Independent Healthcare Advisors who maintain regular contact with administrators are again proactive in advising clients of problems being experience by medical schemes and are therefore able to manage the members' expectations and maintain an open channel of communication which facilitates understanding between the parties concerned. This not only assists members but is also of value to administrators who would otherwise have their call centres inundated with calls from disgruntled members.

To protect the rights of the member regarding:

Independent healthcare advisors protect the interest of its members in the following ways:

- their rights in terms of the Act and associated legislation;
- their rights in terms of the rules of the medical scheme.

The FAIS General Code of Conduct is concerned about advisory and intermediary services. Member protection is not a requirement imposed on representatives in terms of the FAIS Act or General Code of Conduct or the Medical Schemes Act. Independent Healthcare Advisors, as responsible stakeholders, voluntary protect members against decisions of the medical scheme where the medical scheme thwart the rights of members. The legislator, the regulator and the HMI is appreciative of these member protection role by Independent Healthcare Advisors. However, consumers and regulators as stipulated by Bamber and Falkena will not be prepared to pay a fee for these perceived free services. It is for this specific reason that a non-discounted community rated commission model exists[35].

Protect the rights of the member in terms of the Act

34 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

35 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

The intention of waiting periods and late joiner penalties is to protect medical schemes from member behaviour that can expose medical schemes to adverse risk. As mentioned earlier in a previous section, medical schemes often seek to impose these waiting periods and late joiner penalties to discourage membership of members who they view as high risk.

Independent Healthcare Advisors will be able to quote countless examples of where medical schemes have in fact applied both protection mechanisms incorrectly. The members' Independent Healthcare Advisor have had to interact with the medical scheme to have these restrictions removed as they were, illegally applied in the first place in the terms of the Act. Members are not able to challenge a senior underwriter of a medical scheme as they do not know nor understand what their rights are.

Example: "A specific example is the case of a member who was retrenched by an employer who operated a restricted membership medical scheme. The rules of the employer medical scheme noted that only current and past (in the sense of continuation members) employees of the group could be members of the restricted medical scheme. This member had more than two years' continuous cover with the restricted scheme and sought to join a specific medical scheme within 90 days of having resigned from the restricted membership medical scheme.

The underwriting decision of the medical scheme was that the member would have all the waiting periods applied. The Independent Healthcare Advisor assisting the member ended up in a heated debate with the medical scheme underwriter as to what constituted a change of employment, where the underwriter maintained that this was not a change of employment as the member had not yet found alternative employment and had not therefore changed his employment.

The decision to underwrite the member and apply waiting periods could be understood if the employer had been part of an open medical scheme as the member could have continued membership in that case. The result of this exchange was a letter of apology from the administrator as they had apparently incorrectly interpreted the legislation and the waiting periods were waived. Nevertheless, on formal registration of the member, the advisor noted that the medical scheme had applied late joiner penalties even though the member was not a late joiner. This decision was also reversed when the advisor contacted the medical scheme." As noted before, there are many documented cases such as this and it is almost impossible for members to properly understand their rights and then have enough knowledge to interact with medical schemes at this level.

Further areas where Independent Healthcare Advisors often assist members are with stale claims not processed by administrators. Many documented cases exist where the administrator apparently has no record of the claim being submitted. Independent Healthcare Advisors often assist members by obtaining proof of submission from service providers and then getting these decisions reversed.

Protect the rights of the member in terms of the medical scheme rules

Members are not given copies of medical scheme rules when they apply for membership and are ignorant of such rules. These rules are complicated legal documents that are difficult to understand. This can lead to members having their claims repudiated as they lack the knowledge and understanding which is inherent to the Independent Healthcare Advisor. Healthcare Advisors can provide an invaluable service in assisting members when such claims are repudiated, by helping members understand the nature and extent of the cover they have purchased, and are also well equipped through their knowledge to challenge medical schemes when the rules are inappropriately applied to members

Undisputed value of the Independent Healthcare Advisor

The Independent Healthcare advisor undisputedly adds value to the private healthcare environment. The following statement contained in the HMI report is supported and explained in this section of this document. **"We believe that brokers play an important role in advising members[36]"**

36 HMI report, Chapter 10

Research conducted

The following extensive research has been conducted regarding the role of the Independent Healthcare Intermediary:

The following consumer research was conducted or consulted:

- Stakeholder analysis report commissioned by the CMS
- Twig report on research commissioned by
- Project Fair Commissioned by the FSB
- Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa, 2001
- Media reports and advertisements
- Interviews with administrators
- Fair Treatment project commissioned by CMS
- Desktop research from MARSH
- Desktop research from AON
- HMI Healthcare consumer survey

The Need for an Independent Healthcare Advisor

Consumer based research supports the notion that the professional Independent Healthcare Advisor contributes positively to the private medical scheme environment. In this research it was indicated that:

- Consumers are easily exploited. Independent Healthcare Advisor assist in protecting their clients against exploitation. This is significant as the research was conducted on members of medical schemes who are in a far more advantageous position than the target market proposed for low-income medical schemes. Consumer education by Independent Healthcare Advisor is a necessity and not a luxury.
- Consumers of private medical schemes and their employers are unwilling to pay the Independent Healthcare Advisor. This is significant as the research was conducted on members of medical schemes who are earning substantially more than prospective members of the proposed low-income medical schemes are earning.
- Members of medical schemes accept brokers as an acceptable distribution channel. Members of medical schemes require Independent Healthcare Advisor services as defined in the Medical Schemes Act. The quality of the services offered by Independent Healthcare Advisor is more acceptable than those of administrators of medical schemes.
- More and more consumers make use of Independent Healthcare Advisor services.

The following are extracts of the research:

- "Some 21% of Medical Scheme beneficiaries could not recall the names of their medical scheme"[37]
- "44% of beneficiaries are not convinced that medical schemes serve the interest of beneficiaries"[38] "Poorer beneficiaries are least satisfied."[39] The following issues and concerns account for the extent of dissatisfaction:[40]

37 Stakeholder analysis report, p8

38 Stakeholder analysis report p17

39 Stakeholder analysis report, p8

40 Stakeholder analysis report p127

- Cost of cover
- Coverage of claims, specific and general
- Delays in payment
- Response to complaints
- A suspicion among some of corruption or maladministration"

Consumers reaction relevant to payment for brokers services were as follows:

- "Financial constraints facing many beneficiaries are evident"[41]
- "Only 53% of beneficiaries stated that they were able to pay their accounts and subscriptions every month"[42]
- " … if costs relative to incomes were to rise significantly, there would be an erosion of membership"[43]
- 79 % of members believe that broker remuneration should be paid by the medical scheme and only 6% believe the member should pay the Independent Healthcare Advisors remuneration.[44]
- 60 % of employers believe that the Independent Healthcare Advisors remuneration should be paid by the medical scheme and only 2% believe the member should pay broker remuneration and only 3% believe the employer should pay the Independent Healthcare Advisors remuneration.[45]

It was indicated in this survey that brokers are far more effective than medical schemes. In the TWIG survey consumers were asked to rate the service performance of Independent Healthcare Advisor vs that of medical schemes.[46]

Figure 1: Service levels of Independent Healthcare Advisors versus Medical Schemes

41 Stakeholder analysis report p8

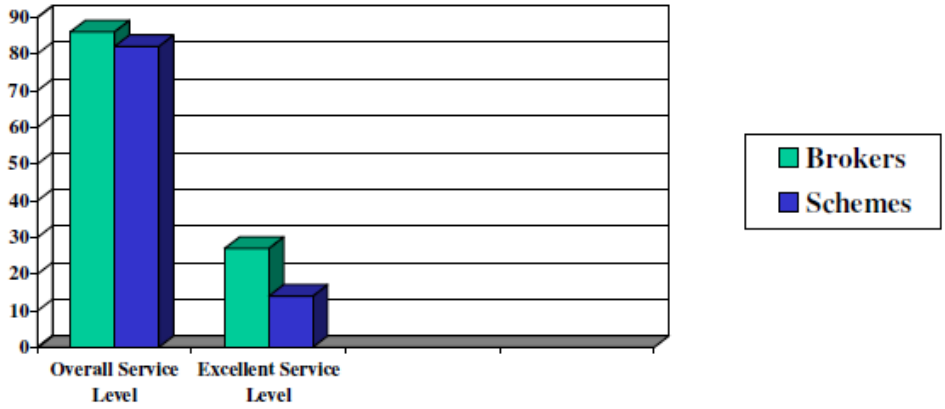
42 Stakeholder analysis report p9

43 Stakeholder analysis report p121

44 TWIG 2004, commissioned by fpi

45 TWIG 2004, commissioned by fpi

46 TWIG 2004, commissioned by fpi



The Independent Healthcare Advisor, Social Solidarity & Regulation as a "free service"

The state President of South Africa said the following[47]: "I must be blunt and say that in healthcare we are looking for collaboration that goes beyond the profit motive "Talking about the public private partnerships he also said that he believes that these partnerships fall into the realm of social responsibility, rather that routine business. Consumer protection is a legal right and not an individual choice. In protecting the consumer, decisions need to be made according to the legal right of consumers and the social responsibility all stakeholders should apply.

Bamber identified the principal that there will always be a need for a commission build into a financial product. This will ensure company protection. The following quote of Bamber, clearly illustrates this point[48].

"If there would be a rational consumer demand for regulatory services, the consumer should be willing to pay for them, and if so, it would be economic to supply it. Regulatory agencies can be viewed as supplying regulatory, monitoring and supervisory services to various stakeholders such as financial institutions, consumers, government, etc. Unlike most other goods and services, regulatory services are not supplied through a market process, but are largely imposed by the regulator. This leads to problems because valuable information is lost about what type and extent of regulation consumers demand, and about how much consumers are prepared to pay for regulation. Consumers are not homogeneous, and yet their different demands cannot be signalled through a market process. Above all, regulation is largely perceived as being a free good as, in the absence of a market for regulation, no market price is generated.

The costs associated with a regulation are not dead-weight costs. However, there is a major limitation in that the consumer may have an illusion that regulation is costless or free good, in which case the demand is distorted. If the perception that regulation is costless is combined with risk-averse regulators, there is a danger that regulation could become over-demanded by consumers and over-supplied by regulators."

"Financial service users express a real need for the financial services industry, it is also expected of intermediaries to be knowledgeable and share that knowledge, and that is, they are seen as a source of information."[49]

Independent Healthcare Advisor a Trusted Professional

47 State Presidents Address to the Health Summit, 2002

48 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

49 Project Fair commissioned by the FSB

"A relatively high number of financial service users indicate that they regard the financial services industry as well as intermediaries as trustworthy. "[50]

Independent Healthcare Advisors, agents, bank officials and financial service product providers are an acceptable channel to all population for the purchase of financial products groups as indicated below. Unions, social groupings and retail operators are not acceptable channels to purchase financial products.[51]

Table 1: Channels used for Financial transactions

Channels usually used for financial transactions								
Financial services users	Total %	Urban %	Peri-Urban %	Rural %	White %	Indian %	Coloured %	Black %
At the bank	39	41	36	36	29	27	40	48
Broker	34	39	22	23	53	53	22	21
From the company office / branch	25	27	28	18	16	6	30	30
Agent	25	23	24	32	18	35	22	30
Telephone	13	13	10	15	15	8	19	9
Mail	5	4	7	8	0	2	2	7
Post Office	2	2	3	5	1		3	4
Internet	2	2		2	3	1	1	1
Professionals like accountants and tax consultants	2	2	1	1	2	1	2	1
Other, like church work, group schemes, unions	1	1	2	0	1		2	1
Retailer (like Shoprite, PnP, Woolworths)	1	1	1	1	0	1	1	1

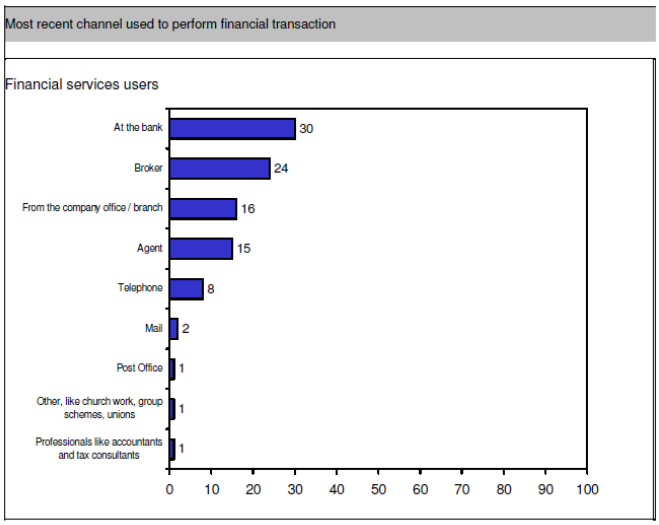
The graph below depicts the most recent channel used to buy, change, surrender or lapse the financial product purchased.[52]

Figure 2: Most recent channel used to perform financial transaction

50 Project Fair commissioned by the FSB

51 Project Fair commissioned by the FSB

52 Project Fair commissioned by the FSB



The most frequent way of establishing initial contact with an intermediately is by word of mouth, or by an intermediary due to a reference. It is also relatively common to contact an intermediary through a company as depicted in the table below.[53]

Table 2: Way of establishing initial contact with intermediary

Way of Establishing initial contact with intermediary

Financial services users	Total %	Urban %	Peri-Urban %	Rural %	White %	Indian %	Coloured %	Black %
A friend / family member recommended them to me	23	25	18	17	29	15	20	21
They got my name from a family / friend of mine	18	18	16	17	17	52	13	17
I contacted them through a company	18	18	17	19	17	18	10	21
From an advert that I responded to - I called them	17	14	26	19	12	1	25	19
They contacted me and I did not know them before	16	13	18	30	10	7	11	24
Through someone at work	12	12	11	10	9	4	9	15
Through work - group scheme	9	10	8	6	9	2	11	9
Went personally to the bank	3	3	3	3	2	1	5	3

Face to face communication is expensive, but due to the education and personalised needs, the most general method of contact as depicted in the table below.[54]

Table 3: Method of last communication with intermediary

53 Project Fair commissioned by the FSB

54 Project Fair commissioned by the FSB

Method of last communication with intermediary								
Financial services users	Total %	Urban %	Peri-Urban %	Rural %	White %	Indian %	Coloured %	Black %
Face to Face	70	69	71	74	60	71	67	78
Telephone	24	26	20	20	37	26	29	13
Mail	5	4	9	6	2	2	3	9
E-mail	0	0	~	0	1	1	1	~

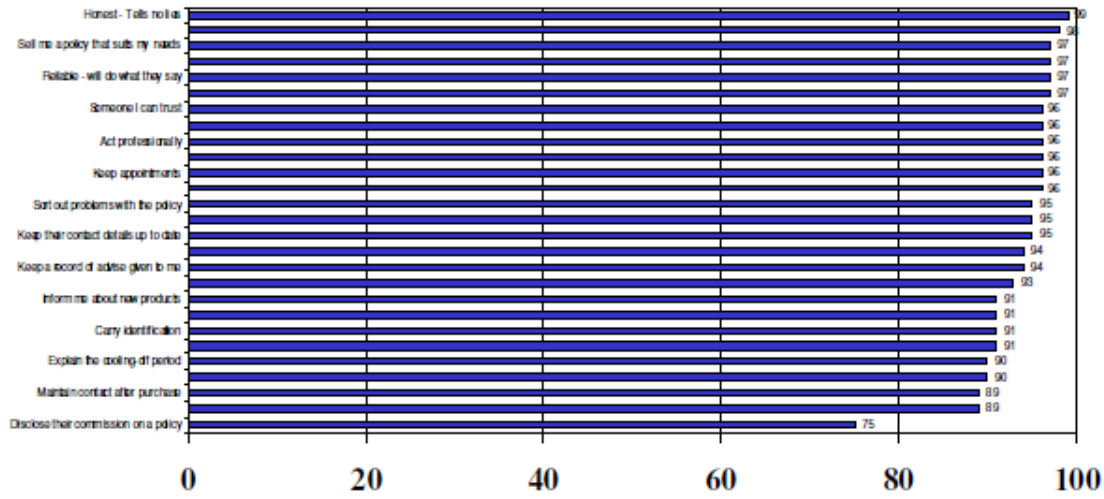
Consumers have frequent contact with their intermediary, which is clearly depicted in the table below.[55]

Table 4: Frequency of interaction with intermediary

Frequency of interaction with intermediary								
Financial services users	Total %	Urban %	Peri-Urban %	Rural %	White %	Indian %	Coloured %	Black %
Weekly	3	4	1	1	4	23	3	3
Monthly	28	26	27	36	17	6	30	37
Every three months	19	20	20	15	16	31	13	21
Twice a year	14	15	9	18	21	20	17	8
Every year	16	17	19	11	23	24	17	11
Less often than once a year	19	18	24	20	19	17	20	19

Financial service users from different races and areas have similar expectations from Independent Healthcare Advisors. The graph below clearly depicts these expectations.[56]

Figure 3: Financial service expectations



The table below depicts the number of consumers that indicated that they are extremely satisfied or satisfied with the Independent Healthcare Advisors services.[57]

55 Project Fair commissioned by the FSB

56 Project Fair commissioned by the FSB

57 Project Fair commissioned by the FSB

Table 5: Different satisfaction levels with interaction with intermediary

Differences in satisfaction with intermediary conduct - extremely satisfied or satisfied								
Financial services users	Total %	Urban %	Peri-Urban %	Rural %	White %	Indian %	Coloured %	Black %
Dress respectably	91	92	92	86	94	97	91	89
Act professionally	89	90	91	84	92	94	90	88
Sell policy that suits my needs	89	89	91	85	90	95	93	86
Explain options available to me	88	87	93	89	89	96	89	86
Someone I can trust	88	87	92	89	87	96	90	86
Answer all questions / queries	87	86	94	88	89	93	90	84
Keep appointments	87	86	92	84	90	85	86	84
Keep a record of advise given	85	85	87	86	89	87	87	82
Sort out problems with policy	85	84	89	84	88	91	89	81
Carry Identification	84	85	88	80	86	87	91	81
Return Calls	84	83	88	82	89	89	69	77
Maintain contact	84	83	86	81	87	73	87	81
Show qualifications	83	86	82	70	86	95	91	78
Financial needs analysis	83	82	90	85	87	87	85	78
Inform me about new products	83	82	89	80	84	85	84	81
No hiding of information	82	82	86	82	84	87	85	79
Explain the cooling-off period	79	79	85	79	84	86	81	76
Disclose commission	78	80	74	71	82	75	85	72

The Independent Healthcare Advisors' contribution to the Fair Treatment of Consumers

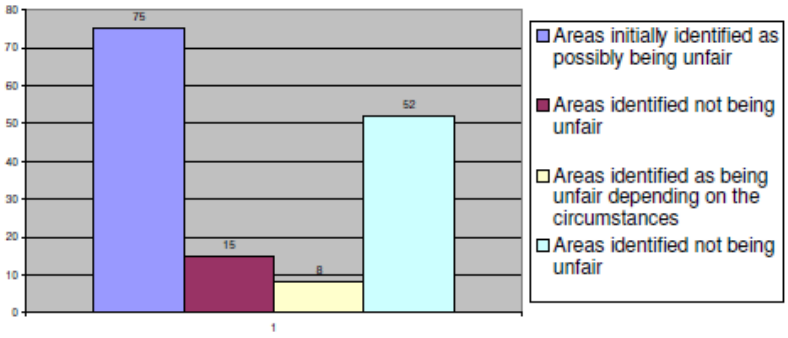
The Council for Medical Schemes identified 75 areas of complaints, which were uncovered during a random survey of medical scheme members[58]. These areas of unfairness were divided into 6 categories namely:

- Information and marketing
- Contributions
- Benefits
- Administration
- Intermediaries
- Member participation

It was found that 15 of the identified areas of unfairness cannot be classified as being unfair and 8 areas of unfairness may be classified as being unfair due to circumstances. The graph below depicts the areas of unfairness and the findings of the Council for Medical Schemes relating to unfairness.

Figure 4: Areas of unfairness

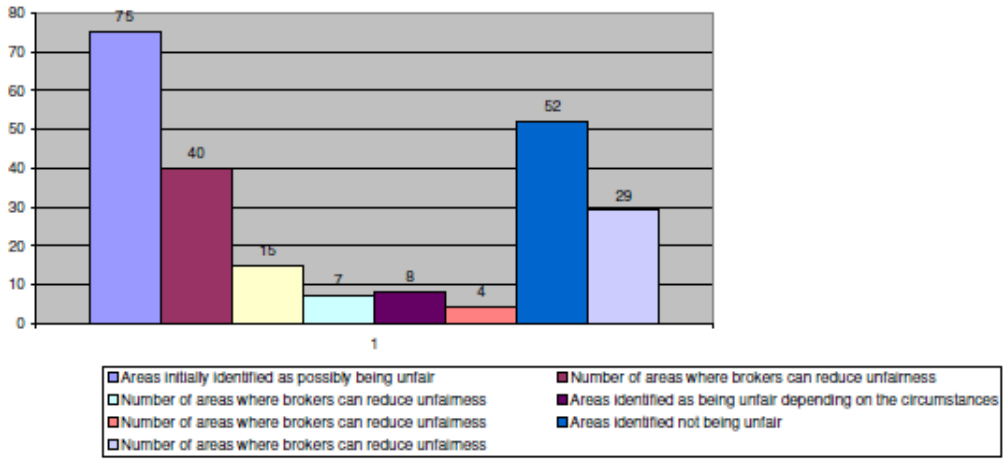
58 Fair Treatment Project



Every stakeholder should take responsibility for reducing possible unfairness. It can be argued that unfairness is an undesirable business practice and in this regard the Minister of Health has been mandated to declare certain practices as undesirable business practices. The responsible action of medical schemes, administrators and brokers can also lead to a reduction in possible areas of unfairness. The following summary is provided:

- From the 52 areas finally identified as being unfair, Independent Healthcare Advisors can assist in at least 29 areas to reduce unfairness.
- 15 Areas were identified as not being unfair, however Independent Healthcare Advisors can assist in seven of those areas to reduce consumer frustration.
- 8 Areas were identified that could be unfair depending on the circumstances. Independent Healthcare Advisors can assist in 4 of these areas in reducing unfairness.
- In total, Independent Healthcare Advisors can, and do, assist in 40 of the areas that were identified as areas that can be unfair.

Figure 5: Independent Healthcare Advisors reducing unfairness



The Registrar of Medical Schemes at the Fair Treatment Project conference made the following points regarding the increasing number of decisions medical scheme consumers are facing:

- "Which Medical Scheme to join? What does it offer?
- Which benefit option to join?
- What is pre-authorisation and how does it work?

- How much to spend on medical savings accounts? Why?
- How extensive are any co-payments? How do I fund these?"

The Registrar of Medical Schemes also provided to the delegates at the Fair Treatment Project the conference findings of international and local research. These findings show that consumers are very inexperienced about dealing with insurers / financing intermediaries. The following points were made:

- "In the UK, 30% of pension funds policy holders did not know that their money was invested in the stock market;
- 56% said that they found it hard to understand insurance policy leaflets;
- Many members cannot make a distinction between their scheme and administrator,
- Many do not know how benefit options work or what they are;
- And of course, even fewer understand the notion of PMB."

In most cases medical scheme membership will be the most expensive "insurance" a consumer will purchase as part of their portfolio of policies to protect their assets and the wellbeing of themselves and their family. This reinforces the fact that it is critical for the consumer to make an informed and appropriate choice of health care cover.

When commission was removed from administrators and placed under the ambit of medical schemes, without conducting a cost benefit or impact analysis, a reduction in administration expenses was expected. Increases in administration expenses, however, exceeded CPIX, and the change in the broker remuneration model, although better regulated, did not result in overall savings to the industry. Medical schemes should have been in a cost neutral position.

A global view on the Independent Healthcare Advisor

Global commission levels differ from country to country. Also, the type of service and legislative background differs from country to country. In South Africa social solidarity and community rating frames our medical scheme legislation. Therefore, a direct comparison of commission levels across countries cannot be made. However, a mere disregard of the trend of higher commission in less restrictive regulatory environments should also not be ignored. According to Marsh, a Global Financial Service Provider Independent Healthcare Advisors earn substantially more globally than in South Africa as depicted in the table below[59].

Table 6: Healthcare Commission Levels: Globally

Country	Commission levels
USA	12% for the 1st year and 5% for the 2nd year and thereafter
Mexico	Depending on the services up to 20%
Brazil	5%
UK	5% with a cap on the maximum commission that can be earned
Australia	3-5%
New Zeeland	5 – 10%

According to Aon, a Global Financial Service Provider Independent Healthcare Advisors who sell the BUPA product earn 10% of the annual premium which is substantially more than in South Africa.[60] Bupa operates in 190 countries and cover over 22 Million people[61].

The following commission levels are paid by Aviva in the UK[62].

59 MARSH Desktop Research

60 Aon Desktop Research

61 BUPA Corporate Brochure

62 Aviva Healthcare Zone

Table 7: AVIVA commission levels

Type of commission	Commission levels
Renewal on switch	30% initial and 10% renewal commission
Newly underwritten	40% initial and 10% renewal commission

The Right Mortgage and Protection Network is a completely independent Network for mortgage and protection brokers with over 300-member firms across the UK. They have published the PMI (Private Medical Insurance) commission rates for 7 different health insurers operating in the UK.[63]

63 https://therightnetwork.co.uk/the-right-pmi-health-care/

Table 8: Right Mortgage and Protection Network – PMI Commission Levels

Provider	Product	Gross Rate
ALC	Individual	15.25%
	Individual Renewal	13.5%
April UK	Individual	45%
	Individual Renewal	6.3%
	SME	20%
	SME Renewal	7.5%
Aviva Health	Individual	54%
	Individual Renewal	5%
	Company	25%
	Company Renewal	9%
	International	15%
	International Renewal	4.5%
AXA PPP	Individual	54%
	Individual Renewal	4.5%
	Company	18%
	Company Renewal	7.2%
	Company Switch	16.2%
	Company Switch Renewal	7.2%
	International	18%
	International Renewal	4.5%
Bupa	Individual	45%
	Individual Renewal	6%
	Company	15%
	Company Renewal	6%
CS Healthcare	Individual	45%
	Individual Renewal	4.5%
Exeter	Individual	60%
	Individual Switch	50%
	Individual Renewal	5%

The Irish Financial Services Regulatory Authority published a report in November 2006 where they investigated the impact of remuneration structures and transparency in the best interest of the consumer[64]. The following findings and comments from the Irish Regulator are important:

- Mere structural change does not result in guaranteed protection. The quality of advice and a strong market conduct approach supported by consumer education improve consumer protection.
- The regulator guarded against introducing additional complexity into the already complex environment.
- The regulator guarded against changing the charging structures where it would negatively impact on the competitiveness of products.
- The regulator ensured that where a direct collection mechanism existed that it was retained.
- The regulator accepted that where there may be a potential conflict of interest that may arise from the commission-based remuneration that it must be dealt with in the context of market conduct structures. In the Irish context this is by way of transparency and disclosure and their new code of conduct that requires advice that is in the best interest of the consumer.
- The regulator conducted a range of consumer research studies understanding the impact of change on the consumer.
- The regulator also sought advice from the Irish Competition Authority. In this it was determined that commission structures should not change but that remuneration needs to be disclosed.
- The regulator sought equivalence between intermediate and direct sales.

HMI Healthcare Consumer Survey

The HMI also conducted a survey of healthcare consumers.

Figure 6: Understanding difference between a medical Scheme and Health Insurance

It is clear from the diagram below[65] that the consumers have a reasonable understanding of the difference between medical schemes and health insurance. This is primarily due to the consumer education that Independent Healthcare Intermediaries conduct.

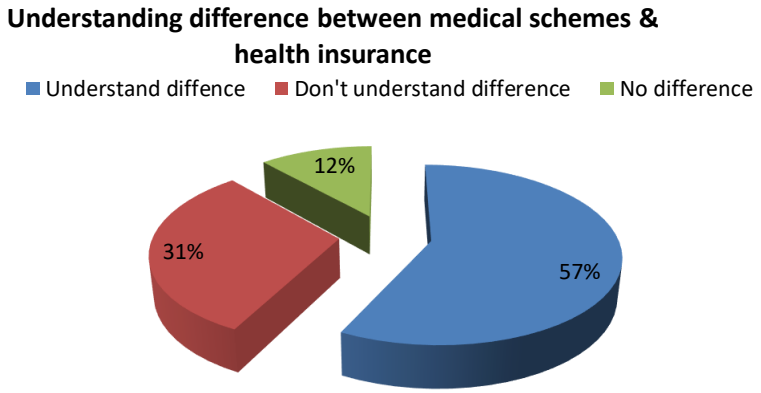


Table 9: How consumers enter medical schemes

The table below[66] clearly indicates that only 18% of consumers do not make use of a broker.

64 Irish Financial Services Regulatory Authority Report: November 2006

65 Competition Commission, Health market Inquiry, Healthcare consumer survey

66 Competition Commission, Health market Inquiry, Healthcare consumer survey

How entered	Percentage
Through employer (However, this is usually a brokered environment)	50%
Through broker	12%
Myself – no assistance from broker	18%
I'm a beneficiary on my partner's medical scheme	10%
I'm a beneficiary on my parents' medical scheme	10%

Figure 7: Knowledge of Cost implications and benefits

It is clear from the diagram below[67] that the consumers have a good understanding of the cost implications and benefits. This is primarily due to the consumer education and guidance that Independent Healthcare Intermediaries conduct.

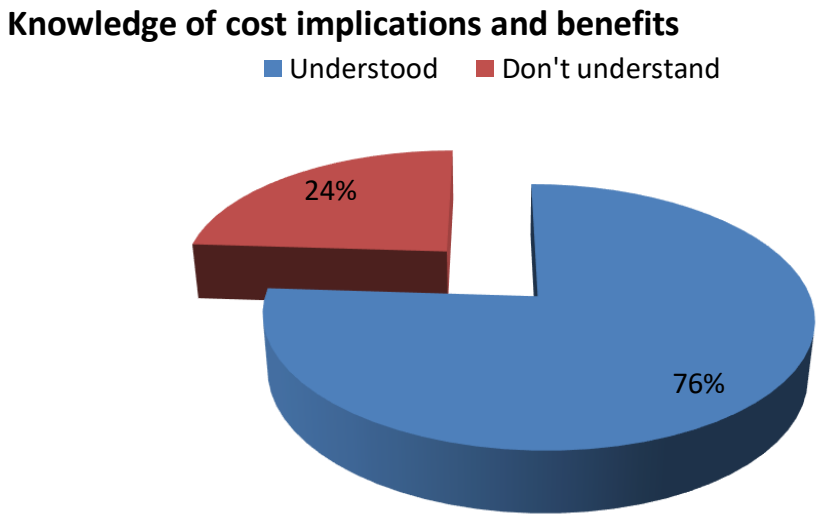
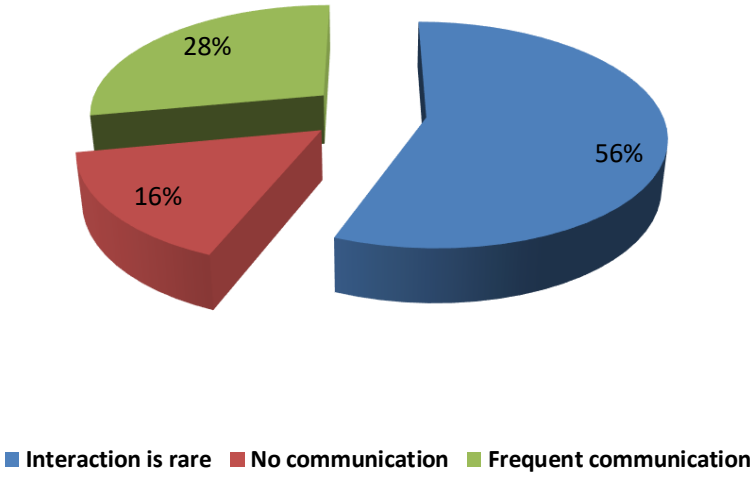


Figure 8: Interaction with the broker

The figure below depicts a disappointing level of interaction with the broker. However, the results in the previous two diagrams could not have been achieved with low broker interaction. An explanation may also be that some of the services rendered by the Intermediary is co-branded or branded by the employer.

67 Competition Commission, Health market Inquiry, Healthcare consumer survey



The moral hazard created by the cap on commission also drive two types of intermediary models:

Reactive model:

Where commission is derived from individuals and the quantum ranges from R11,10 – R90 with an average commission of R60 per family per month it is logical that the intermediary would only be able to afford to render a reactive service. This would mean that the intermediary may employ a call centre which clients can call or office staff that can react to member queries and needs for advice. The able below show the cost of specific services and it supports the reality that in the individual market services would be reactive. This can explain why some members may have a low interaction rate with their intermediary. Some of these intermediaries also use technological platforms such as you tube videos, WhatsApp and websites to make information available to the consumers. This will also reduce the need for personal contact.

Medical scheme members can also when they have complaints approach the CMS for assistance. The CMS complaints service is also reactive. Annually less than 0,05% of beneficiaries contact the CMS with complaints. Therefore, the frequent communication at 28% and infrequent at 56% substantially exceeds the CMS complaints.

Table 10: Table of Services

It would be difficult to find a benchmark of services rendered. Therefore, we have used non-litigation or pleading costs that are used by attorneys in terms of the magistrate's court. It needs to be understood that most attorneys charge more than the fees illustrated. However, at even these

minimum rates the current commission model relating to individual members can only support a reactive service model[68].

Service delivered	Cost	Comment
Correspondence send or received	R 23,50 per page	• Medical scheme applications exceed 10-pages. • Medical scheme brochures exceed 30-pages • Claim statements can exceed 10-pages • Pre-authorisation documents average 4-pages • Membership certificates 1-page • Tax certificate 1-page • Independent Healthcare Advisors must file as an example their record of advice and specific disclosure information. This can easily exceed 10-pages
Sending of a document	R 15	• That would be any detail required by the medical scheme or an application form or medical reports or requests to pay claims etc. • Independent Healthcare Advisors must file as an example their record of advice and specific disclosure information.
Filing of a document	R15	Independent Healthcare Advisors must file/store as an example their record of advice
Telephone call	R 23,50	To resolve a query or to protect members rights could easily require 10 calls.
Telephone consultation	R41 per 5-minutes to a maximum of R 140 per call	
Physical consultation	R 144,50 per 15 minutes	

From the costs above, it is logical that an Independent Healthcare Advisor that operates in the individual market will accept the economic reality that some members will not require service and that when they do that they will reach out to the Independent Healthcare Advisor. This is common in all financial services and is not restricted to medical schemes only.

Proactive Model:

Intermediaries operating in the employer group market deliver their services to members in terms of:

- **Healthcare committees consisting of employer and employee representatives**
- **Helpdesk sessions where they will visit employers and be available to employees. However, although the service is available to all employees making use of the service and meeting with the intermediary is voluntary. Only members with specific needs will make use of the service on a day.**

68 Rules Board for Courts of Law Act, 107 of 1985, Government Gazette number 38399, 23 January 2015

- Meeting with Human resource officers, payroll staff and other executives of the company. These meeting would be to give feedback on service delivery and discussing matters affecting members and the employer. Members benefit from these strategic and operational interventions but does not explicitly know of these services. They, at most, will see it as a free service as identified by Bamber and Falkena[69].
- Member education sessions, newsletters and Induction sessions. Member education sessions and newsletters may be branded for the employer. This may distort the figures to some extent.
- Explanation sessions regarding year end changes
- Call centres or office staff dealing with queries
- Websites and electronic media
- Etc (This is not an exclusive list)

It is also important [70]to note that 92% of the consumers were happy with the information provided to them by their broker and 66% of consumers indicated that their broker provide them with 2-5 options.

The Independent Healthcare Advisor remains a Consumer Partner for Life

Although, Classique Medical Aid Consultants CC can never agree that capping of commission is the correct approach we concede that the current capped environment brought substantial benefits into the market. Some of these benefits are:

- Commission as a percentage of contribution income reduced substantially, and
- Commission expenditure can quite accurately be budgeted for, and
- Capping reduced the need to suggest higher levels of cover to earn an increased commission, and
- Capping further supports the notion of social solidarity and community rating, and
- Capping eliminated the incentive to churn members between medical schemes.

Currently members or employers are the only people who can decide to make use of a broker or not. Evidence proves that more members elect to make use of a broker now than ever before. Some members, however, elect not to use the services of a Independent Healthcare Advisor. This does not mean that costs are saved, but merely that the medical scheme now becomes the direct transaction entity. This means that the additional acquisition and servicing of the member becomes the responsibility of the medical scheme, with all the inherent costs. It is illogical or irresponsible in a differentiated rate proposal to expect the medical scheme, or an administrator to pick up the responsibility for marketing, acquisition of members and servicing of members at no additional cost. Furthermore, if medical schemes delegate this to their administrator, who by law has an arm's length relationship with the medical scheme, and are highly incentivised by profits, a logical expectation would be an increase in administration fees. So, the initial perceived saving becomes a fictional saving with no prospect of any real savings.

Independent Healthcare Advisors are also not a driver of complaints to the RoMS or the FAIS Ombud. The tables below indicate the complaints regarding Independent Healthcare Advisors.

Table 11: Complaints to the RoMS

Year	Number of Complaints to the RoMS	Complaints regarding Independent Healthcare Advisors
2016	4 823	3[71]

69 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

70 Competition Commission, Health market Inquiry, Healthcare consumer survey

712016 Annual report of the RoMS, 2 complaints referred

2015	5 089	6[72]
2014	5 223	5[73]
2013	5 008	8[74]
2012	5 915	3[75]

The number of complaints lodged with the RoMS is negligible compared to other complaints[76].

Table 12: Complaints to the FAIS Ombud

Type of Complaint	Number of complaints
Forex	12
Investments	222
Long-term insurance	18
Healthcare	1
Property syndication	33
Retirement advice	5
Short-term insurance	154
Non-FAIS	1

The number of complaints lodged with the FAIS Ombud[77] is negligible compared to other complaints. It is abundantly clear that Independent Healthcare Advisors does not pose any market conduct risk observed by the two regulators.

We firmly believe that there is a need for the many services offered by Independent Healthcare Advisors, and specifically for those direct services that are critical to the consumer making an informed decision.

The challenges of dual regulation

In broad terms, both market conduct and consumer protection are the elements of financial regulation and supervision focusing on financial institutions' behaviour, including non-distortive and non-abusive business practices and information disclosure in providing services to the retail consumers[78]. "'Prudential' management of financial services looks at the safety and soundness of institutions with a focus on risk, capital and liquidity, while 'conduct' focuses on how consumers are impacted by the actions of financial institutions."[79] The effectiveness of the consumer protection regime is also supported by the well operating Financial System Mediator (a financial ombudsman) that addresses consumer complaints and contributes to the comprehensive financial consumer protection framework.

72 2015 Annual report of the RoMS, 5 complaints adjudicated in favour of broker and 1 complaint invalid

73 2014 Annual report of the RoMS, no detail of adjudication

74 2013 Annual report of the RoMS, no detail of adjudication

75 2012 Annual report of the RoMS, no detail of adjudication

76 Annual reports of the RoMS

77 FAIS OMBUD website

78 The World Bank's Good Practices for Financial Consumer Protection use the terms "consumer protection," "business conduct," and "market conduct" supervision interchangeably.

79 Andrew Bailey, deputy governor and chief executive of the Prudential Regulatory Authority, May 2013, https://www.professionaladviser.com/ifaonline/news/2265707/pra-fsa-botched-conduct-and-prudential-regulation-mix

The Financial Services Conduct Authority regulates conduct – i.e. behaviour. Mis-selling of financial products would be a typical example. The Prudential Regulation is concerned only with safety and financial soundness.

The Twin Peaks approach to financial regulation in South Africa, is designed to underpin a comprehensive regulatory system with two main aims[80]:

- To strengthen the financial safety and soundness of financial institutions by creating a dedicated Prudential Authority (PA)

- To better protect financial customers and ensure that they are treated fairly by financial institutions by creating a dedicated market conduct authority – the Financial Sector Conduct Authority (FSCA)

Healthcare Intermediaries are regulated by the FSCA as well as the CMS. The FSCA is tasked with only focussing on market conduct regulation. As such they specialise in market conduct practices with the dedicated focus in better protecting financial customers and to ensure that they are treated fairly. On the other hand, the CMS attempt to regulate private medical schemes and intermediaries by conducting a prudential and market conduct function. In a resourced constrained environment, it is very difficult to be efficient in your regulatory oversight if you must focus on prudential as well as market conduct oversight. The FSB with more resources than the CMS were not able to do this as efficiently and effectively as required to maximise consumer protection. Whilst the intention of the CMS is good they are resource and competency restraint.

We have explained earlier that AHABA provided the following financial planning example to the Portfolio Committee on Finance[81]:

> "**A case study that illustrates that health care advice forms part of financial advice**
>
> Mr. J, a very healthy 30 years old, just married with a newly born baby asks Mr. P an accredited health care broker and certified financial planner to draw up a comprehensive financial plan. Mr. J's previous financial needs in order of importance were:
>
> ☐ Short term insurance
> ☐ Short term savings
> ☐ Investment plan
> ☐ Medical scheme
> ☐ Life cover
> ☐ Disability
> ☐ Retirement
>
> After a comprehensive needs analysis and current provisions it was discovered that his priorities should change as follows:
>
> ☐ Increase disability cover dramatically;
> ☐ Improve retirement provision to maximise tax benefits;
> ☐ Increase life cover marginally;
> ☐ Reduce short term insurance;
> ☐ Reduce short-term savings due to the tax deduction being exceeded;
> ☐ Retaining investment portfolio constant but invest portfolio more aggressively; and
> ☐ Reduce medical scheme to a less comprehensive medical scheme or option.
>
> These proposed amendments to Mr. J's portfolio were clearly explained with full disclosure of the impact it will have on his family's risks.
>
> A few months later he was hospitalised due to an accident and suffered complications. His expenses were R50

80 TWIN PEAKS IN SOUTH AFRICA: RESPONSE AND EXPLANATORY DOCUMENT

81 Hansard 2 October 2001

000 more than his medical scheme limit.

He is upset and wants to seek recourse for bad advice, to who will the complaint be lodged? (The FSB or the Council?)

Should Mr. J complain to the Council, it might be decided that the advice was inappropriate (only investigating singular product advice). Should Mr. J complain to the FSB, it might be decided that the advice was totally appropriate (investigating a comprehensive financial need analysis).

The only regulator able to analyse a comprehensive needs analysis, and consequently the financial advice, would be the FSB. The public and all industry related associations accepted this principle."

During the HMI oral evidence and public hearing process the CMS expressed a concern that Independent Healthcare Intermediaries would encourage members to buy down to sell Gap products. It is also important to note that the HMI could not find evidence of this practice. We also respectfully disagree with the CMS's submission in this regard. The buy down trend is primarily due to affordability constraints members experience and no prove exist that it is broker induced. Further, when a consumer buys down they also lose quite a lot of other benefits. One example is that the amount allocated to savings accounts may be substantially less. The formularies and protocols for lower options are usually also more restrictive than higher options. This is not covered by GAP products. What is also important is to note that the concern expressed by the CMS does not consider any of the other financial planning needs the consumer will have to meet with limited disposable income.

As a regulator concerned with the wellbeing of medical schemes the CMS acted as predicted in 2001 in that the buy down must be wrong, and the advice must be questionable. The comment of the CMS may be symptomatic of the fact that the CMS is tasked with only understanding and regulating medical schemes, whereas the Independent Healthcare Advisors look after the full financial portfolio of the member. This regulatory misunderstanding is perhaps the primary reason why the conduct of Independent Healthcare Advisors should be regulated by the FSCA who understands the relationship between a range of financial products and the responsibility to provide appropriate advice. This level of understanding falls outside the scope of the CMS and their misunderstanding is to be expected.

I about 2003/2004 the CMS dispensed with their code of conduct for Brokers stating they would be using the code of conduct for intermediaries governed by FAIS. This made sense. However, in 2018 the CMS published a model contract between Independent Financial Advisors and medical schemes. The danger is the arbitrage between the two regulatory bodies. The CMS[82] focussed more on the form of record keeping[83] whereas the FSCA[84] focussed on the form as well as the substance. Par 8 of the FAIS General Code of Conduct specifically address the content of the types of advice that should be recorded. Complying with the CMS requirements could mean that an intermediary comply with keeping inappropriate records and records of poor advice, whereas the FSCA require a qualitative approach to recordkeeping. The FAIS Act and the FAIS General Code of Conduct are in direct conflict with each other on two key areas, namely; Firstly, the FAIS Act do not require best advice. In fact, the General Code of Conduct only require suitable advice and read with par 2 it would mean advice that is in the interest of the member and no other person. Best advice cannot be defined and is open to interpretation. It is for this reason that the General Code of Conduct in par 8 rather propose an internationally recognised 6- step

82 Model Intermediary agreement published by the CMS, par 7,3

83 Model Intermediary agreement published by the CMS, Annexure A, par 1,12

84 84 FAIS General Code of Conduct, par 3,8 & 9

process[85]. Secondly, the CMS require the intermediary to act in the best interest of the member and the medical scheme. The FAIS General code of conduct and specifically par 2 is in direct conflict with the CMS requirement. The interest of the member and the interest of the medical scheme is mutually exclusive. The intermediary can only serve the interest of the member of a medical scheme and no one else. The FAIS Act also places this obligation on the intermediary. The disclosure requirements contained in the FAIS General Code of Conduct is far more comprehensive and protect the healthcare consumer far more than what is required by the CMS.

Debunking common myths regarding the independent healthcare intermediary

Myth 1: Broker paid by medical scheme & therefore the medical scheme can control the broker

The argument that because a broker is paid by a medical scheme, therefore the Independent Healthcare Advisor is controlled by the scheme, is based on a generalisation and a misunderstanding of the real facts. Furthermore, the conclusion that to rectify the system, members must be allowed to opt-in and opt-out of using an Independent Healthcare Advisor. When members opt-out they will then receive a contribution discount. This conclusion ignores the community rating principles agreed to when broker commission was changed from an uncapped to a capped amount. Before this is discussed in detail an explanation of the relevant legislation and regulations are required[86]:

- Section 65 (5) prohibits a medical scheme to compensate a broker directly or indirectly in any way that contravenes the Medical Schemes Act[87].
- Section 65 (6) (b) states that a member and an employer who appoints the broker on behalf of its employees is one of the people that pay a broker. This section must be read with section 65 (6) (a) where it states that a medical scheme can also pay a broker. The actual entity that make the payment is the medical scheme, but it is made on behalf of the member or the employer. The medical scheme is the conduit but that is all it is. The medical scheme can make no payment if the member or employer did not appoint a broker.
- Regulation 28(1) and regulation 28 (6) (a) requires that a contract exist between a broker and a medical scheme.
- Regulation 28(2) states that the commission is payable for two functions namely the introduction of a member to a medical scheme and the provision of ongoing services to that member. This section clearly emphasises the legal relationship between the independent healthcare advisor and the member. Further the legal construct of this section clearly isolates the medical scheme as merely a conduit and not a beneficiary of the services of the independent healthcare advisor. The independent healthcare advisor is placed in a service relationship to the member for earning commission and has no responsibility towards the medical scheme.
- Regulation 28(2) (a) and (b) prescribe the maximum amount of commission that can be paid.
- Regulation 28(3) prohibits a medical scheme from differentiating the commission based on the risk pool. This prohibition on medical schemes further supports the notion that the medical scheme is merely acting as a commission payment conduit and cannot and should not influence the behaviour of independent healthcare advisors for placing better risk with the medical scheme or for not acting in the

85 FPI 6-step process

86 HMI preliminary report 5 July 2018, p118, par 247

87 HMI transcript, 3 March 2016, p223

best interest of its members. This regulation must be read with regulation 28 (4) that allows medical schemes to apply a sliding scale but not in such a way as to attract better risk.

- Regulation 28 (5) merely allow a medical scheme to only pay broker commission after receipt of the monthly contributions from a member or employer group. This again support the notion that a medical scheme merely acts as a conduit for paying broker commission.
- Regulation 28 (6) (b) allows a broker to charge a member or an employer appointing a broker on behalf of its employees an additional professional fee[88]. This fee will be in addition to the commission contained in regulation 28 (2) (a) and (b)
- Regulation 28 (7) instructs a medical scheme to immediately stop paying a broker if they receive a notice from a member or an employer who appointed a broker on behalf of its employees that they no longer require the services of the broker. This section in the regulations is maybe the most directive indication of the real person who pay the broker. The fact that the medical scheme must honour the member's or employers' instruction without any discretion on behalf of the medical scheme clearly reduces the role of the medical scheme to only that of a conduit payment agent relating to the commission. The member opts-in and the member opts-out and the medical scheme must honour that decision of the member or employer[89].

The most important tenant of the Medical Schemes Act is social solidarity. This then also lead to the adoption of the principle of community rating. Prior to the current Medical Schemes Act commission was to a large extent unregulated. During and after the enactment of the current Medical Schemes Act the regulator and legislator debated the need for the Independent Healthcare Advisor.

After submissions by the Independent Healthcare Intermediary sector to the RoMS and the Portfolio committees on Finance and Health the role of the Independent Healthcare Advisor was accepted. In hindsight, this decision made by the legislator and regulator proved to be correct.

Directly after the role of the Independent Healthcare Advisor was accepted the debate moved to whether commission should be paid or if it should just be fee based, and if commission was to be paid if it must be paid as a once off amount or monthly[90].

The ongoing payment of commission in contrast to a once off commission was chosen. This was primarily based on the notion that the services the independent healthcare advisor renders are of an ongoing nature[91]. This view was supported by the ongoing duties and relationship imposed on financial advisors by the FAIS Act and the ongoing component of broker services as defined in section 1 of the Medical Schemes Act[92]. It is also important that there is no difference in remuneration between the placement and ongoing service rendered by an Independent Healthcare Intermediary. This was purposely structured to avoid churn as well as to ensure that there is no systemic incentive for any undue influence of medical schemes over Independent Healthcare Intermediaries to place members with them or to retain members with them. The Independent Healthcare Intermediary stay in a cost neutral position.

- The final debate that had to be resolved was whether the Independent Healthcare Advisor must get the fee directly from the member or if it must be paid as a commission from the medical scheme contribution[93]. Initially the regulator held the view that he who benefits from the services of the Independent Healthcare Advisor should pay for those services[94]. On face value this argument made sense. However, after careful consideration of the multiple beneficiaries of the services of the Independent Healthcare Advisor a realisation was created that only a singular beneficiary from the independent advisors' service does not exist. The services of an Independent Healthcare Advisor

88 HMI preliminary report 5 July 2018, p119, par 249

89 HMI transcripts3 March 2016, p221

90 HMI preliminary report 5 July 2018, p115, par 227

91 HMI Transcript 3 March 2016, p205

92 HMI preliminary report 5 July 2018, p116, par 228

93 HMI preliminary report 5 July 2018, p119, par 250

94 HMI transcript 3 March 2016, p231

benefitted the member and the employer in cases where the employer appointed an independent healthcare advisor. However, Discovery and other medical schemes in their submission to the Health Market Inquiry and to the RoMS and parliament before provided prove that the services of the Independent Healthcare intermediary also benefited them in that they have less queries to deal with. Because the Independent Healthcare Advisor also protects the rights of their members where medical scheme takes decisions contrary to the rules of the medical scheme or the Medical Schemes Act the RoMS is also a beneficiary of the work of the Independent Healthcare Advisor. Therefore, to proceed with the principle of he who benefits must pay became a logistical challenge. Bamber and Falkena also refers to these situations and multiple beneficiaries as a free service that cannot attract a commercial value[95]. It also should be noted that in terms of research conducted 79 % of members believe that broker remuneration should be paid by the medical scheme and only 6% believe the member should pay the Independent Healthcare Advisors remuneration.[96]

- 60 % of employers believe that the Independent Healthcare Advisors remuneration should be paid by the medical scheme and only 2% believe the member should pay broker remuneration and only 3% believe the employer should pay the Independent Healthcare Advisors remuneration.[97]

According to Discovery[98], there are approximately 25,000 policies on DHMS (48,000 lives) which are classified as orphaned policies. Orphaned clients have no active broker and are not proactively serviced (typically inbound servicing when require assistance). Reason why a client may be 'orphaned' is that their advisor has left the industry but not passed on details as to what should happen with the client or either the client or broker fires each other, without a replacement advisor. These policies have been compared to all other policies on DHMS, with the following insights:

- The servicing load of orphaned clients is materially greater than intermediated clients, as measured by call interactions and email interactions. The analysis considers all clients with 12 months of exposure in 2017and compares clients with similar frequency of utilising benefits (clients with high frequency of utilisation of benefits are likely to have greater email and call interactions).
  For example, orphaned clients with high frequency of utilisation of benefits have 9.2% greater annualized call interactions than all intermediated clients (16.4% if considering only clients of corporate brokers) and 7.1% greater annualized email interactions (17.2% vs clients of corporate brokers).
  There is a financial cost for increased servicing levels however this cost is less than the amount an individual may pay in commission.
  Please note that the analysis is based on call and email interactions that have been logged, thus understates that total calls received by Discovery from DHMS members (shorter calls may not always be lodged; thus, no interaction would reflect)
- Orphaned clients have significantly lower plan movements compared to intermediated clients. For example, in January 2017 2.0% of orphaned clients upgraded or downgraded their policies vs 3.4% for all intermediated clients (3.7% for clients of a corporate broker). This speaks to the role of advisors in assisting members in understanding year-end changes and reassessing their plan choice given their financial and medical needs.

A more credible argument for commission instead of fees was presented by the Independent Healthcare Advisor. This argument was that in a fee-based environment the only people that will have access to professional advice will only be those that can afford and is willing to pay these professional fees.[99] A good example is found in the legal and auditing profession. The services of these professionals are not affordable for middle to low income earners. It is for this exact reason why the legal aid board and small claims courts were established to provide access to legal expertise for those who can't afford it. South Africa is one of the most unequal societies in the

95 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

96 TWIG 2004, commissioned by fpi

97 TWIG 2004, commissioned by fpi

98 Information provided by Discovery Health, 21 August 2018

99 HMI transcript 3 March 2016, p231

world and it is widely reported that the gap between high income earners and low-income earners are widening and not reducing. In a fee-based environment less people will be able to afford the services of an Independent Healthcare Advisor. It was argued before that it is exactly these vulnerable people in society that benefits most from the services of an Independent Healthcare Advisor but will not be able to afford this valuable service in a fee-based environment. The only way to ensure access to the valuable services of the independent healthcare advisor is to community rate the commission. This argument put to the regulator and the legislator was accepted. A simplistic way of addressing consumer harm is to argue that the existing system is more expensive and that a discounted model will lead to consumer benefits due to the cost saving. At best this line of argument will just defer the same question of consumer harm to a later stage. Exclusionary practices itself is a harm to consumers[100]. In practical sense more than 90% of members make use of the services of an Independent Financial Advisor. This is for the consumer (family) on average R 65 pm but can be as little as R 11,10 and maximum R 90. This gives the consumer access to unlimited advice and intermediary services as defined by the FAIS General Code of Conduct[101]. However, in a fee-based model of say R 750 per hour a family will be able to buy less than 5 minutes of an Independent Healthcare Advisors time per month with the saving achieved. Alternatively, only one-third of members will be able to afford the services of the Independent Healthcare Intermediary. The loss to the consumer far exceeds the possible gain of a mere, on average R60 pm saving.

The moral hazard that is created when a fee-based model instead of a commission model is applied is that in some cases the fee will exceed the value of the claim and as such members will not prosecute matters with medical schemes where they have a legal entitlement to. Let's assume a medical scheme underpaid a PMB account that they should have paid and as an example the short-payment is R 350. It will only be in the interest of the member to use an Independent Healthcare Advisor if the fees are less than R 350. However, if the member then doesn't exercise their rights the Medical Scheme unduly benefits.

In hindsight the decisions taken by the RoMS and the legislator relating to commission was correct and the following benefits were derived from the decision:

- More consumers, year-on-year, made use of the valuable services of the Independent Healthcare Advisor.
- The commission paid to Independent Healthcare Advisors in real terms increased at a substantial slower pace than other expenses. Even the fees paid by medical schemes to the RoMS increased at a substantially higher pace than commission.
- Changes to commission and specifically the cap on commission ensured that commission was not a driver of increased cost in the private medical scheme market.
- The commission payable is manageable and can be accurately budgeted for.
- Government also has an accurate grasp of the commission payable, whilst in a fee-based environment government will have no idea what the actual fees are.
- The commission payable can be accounted for in terms of B-BBEE legislation. Where fees charged directly to members the need for independent financial advisors to be B-BBEE compliant will fall away. This will seriously negatively affect transformation in the advisory field.

The medical schemes merely act as the conduit for payment of commission. The member can at any stage decide to cancel the appointment of the Independent Healthcare Advisor and transact directly with a medical scheme. Medical schemes also may not refuse to deal with a member that decides to transact directly with them[102][103]. Therefore, an Independent Healthcare Advisors' advice will remain independent in so far as he or she will seek out the best possible solution for his or her client, to ensure that the client becomes a member of a medical scheme and, in turn, the medical scheme in question pays the independent healthcare advisor the legislated level of commission.

100 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

101 FAIS General Code of Conduct

102 Regulation 28 (7)

103 HMI preliminary report 5 July 2018, p118, par 248

The FIA delegation to the HMI mentioned some examples where Independent Healthcare Advisors represent their client's interest with the result that it has huge cost implications for medical schemes. One can argue that these actions does not carry favour with the medical schemes, or even worse agitate medical schemes. Some of the examples provided by FIA[104] and other Independent Healthcare Advisors clearly indicate a value-based consulting approach namely:

- R 1 500 000 refund to a client and its employees
- Enforcement of PMB's to prevent a person's son who was seriously injured from being evicted from hospital[105]
- Resolution of simple queries daily. The resolution of these queries benefits members and not medical schemes.

The table below indicate some of the value rendered by Independent Healthcare Advisors[106] expressed as commission months or years. In addition, the cost of the fee-based service at R 1 100[107] per hour[108] as well as the estimated legal fees are depicted in the table below. It is important to note that the current commission-based model add substantial more value than any fee-based model.

Table 13: Real value added by Independent Healthcare Advisors

Value rendered	Value in commission months/years	Hours spend to resolve query	Cost of fee based service at R 1 100 per hour plus VAT	Estimated legal fees using magistrates court scales
Payment of a PMB claim to the value of R 43 000.	55 years	10 hours 20 minutes	R 13 071	R 43 515
Payment of a triple heart bypass account to the value of R 52 000.	66 years	9 hours 45 minutes	12 334	41 845
Payment of a claim to the value of R 168 000.	215 years	13 hours 15 minutes	R16 761	58 120

The value of the Independent Healthcare Advisor as demonstrated above, is rendered despite the income level or affordability of the member. However, in a fee-based model or direct legal assistance these services would have been unaffordable to most members.

It is abundantly clear from the legislation and regulation that the advice provided by an Independent Healthcare Advisor must be in the best interest of the member and could be compromised due to the mere conduit role of the medical scheme to pay commission. In the unlikely event that an Independent Healthcare Advisor does not act in the best interest of its clients there is enough protection for the member. The RoMS can declare a certain practice as an undesirable business practice. The RoMS can suspend or withdraw the accreditation of the contravening broker. The matter can be referred to the FAIS Ombud who can make restorative justice determinations to the value of R 800 000 per case. The same protection exists where a medical scheme or administrator unduly influence the behaviour of any or all Independent Healthcare Advisors. Although, these legal remedies exist there is no evidence of any systemic failure or large-scale undesirable behaviour from Independent Healthcare Advisors. On the contrary, independent financial advisors add huge value to the healthcare value chain. There are

104 HMI transcript, 3 March 2016, p 219

105 HMI transcript, 3 March 2016, p267

106 HMI transcript, 3 March 2016, p267

107 This rate is aligned to the bottom quartile of the Hourly Fee Rates For Consultants as published by DPSA

108 This rate was calculated using the principle that there are approximately 8 000 brokers earning approximately R1,5bn per annum and want to retain their level of income

not adequate, logical or reasonable grounds for the existence of a need to make any amendment to legislation in how Independent Healthcare Advisors are remunerated.

Myth 2: Because broker is contracted to the medical scheme the medical scheme can control the broker.

The argument that because an Independent Healthcare Advisor is contracted to a medical scheme, therefore the Independent Healthcare Advisor is controlled by the scheme, is based on a generalisation and a misunderstanding of the real facts. The fact of the matter is that an Independent Healthcare Advisor can never be beholden to a medical scheme. The advice function of an independent financial advisor is regulated by the FAIS Act. The FAIS Act prescribes that the advice given must always be in the best interest of the member and not the product provider, medical scheme in this case. The contract between the medical scheme and the Independent Healthcare Advisor will always have to be compliant to the FAIS Act. If the Independent Healthcare Advisor deviates from the FAIS Act and provides advice not in the best interest of the member but in the interest of the medical scheme the FAIS Ombud will impose a fine or restorative justice conditions on the Independent Healthcare Advisor. This is one of the key reasons why the Independent Healthcare Advisors argued that they should fall under the FAIS Act for market conduct oversight.

The commercial contract that exist between Independent Healthcare Advisors and medical schemes exist not because of the commercial interest of any of the two parties. These contracts merely exist because it is a regulatory requirement. Section 65 (2) of the Medical Schemes Act empowers the Minister to prescribe the conditions under which a broker can earn commission from broker services. Regulation 28 (1) of the Regulations promulgated in terms of the Medical Schemes Act specifically prescribe that an Independent Healthcare Advisor must enter into an agreement with a medical scheme to be able to earn commission. The Registrar of medical schemes also published a model contract between medical schemes Independent Healthcare Advisors. This model contract merely regulates the relationship between the two contracting parties to be compliant firstly to the Medical Schemes Act and secondly to be aligned to the fiduciary responsibility the Independent Healthcare Advisor has to the member in terms of the FAIS Act.

The contract between a medical scheme and an Independent Healthcare Advisor merely exist as a regulatory compliance requirement. Any interpretation that the contract seeks to control the actions of the Independent Healthcare Advisor in a way that is not in the best interest of the member is merely speculative and factually misplaced.

The CMS provided guidelines to medical schemes regarding the model rules. The following quotation from these guidelines is perhaps the most direct and powerful tool to understand the contractual relationship that exists between the Independent Healthcare Advisor, the member and the medical scheme. The Independent Healthcare Advisor is the agent of the member and the CMS is very directive in this regard. This should not be disputed at all.

> "The broker fraternity is recognised in this relationship provided such person or organisation is accredited as required by law and they comply with the prescribed requirements throughout. The following measures are of particular importance[109]:
>
> - The broker is recognised as the agent of the member and the member is not compelled to make use of broker services in obtaining membership of a medical scheme. Medical schemes may accordingly not allocate members to a broker for purposes of providing broker services and remunerating such broker."

In support of the guidelines provided by the CMS it is important to note that contractually the medical schemes do not accept liability on behalf of the Independent Healthcare Advisor. Should a member have a problem with the advice rendered by the Independent Healthcare Advisor, such member can approach the FAIS Ombud who can, if the advice provided by the Independent Healthcare Advisor is inappropriate, award restitution to an amount of up to R 800 000. It is also important to note that the CMS does not have any power to award any

109 CMS Explanatory Memorandum to the Model Rules

compensation to a member regarding inappropriate advice by the Independent Healthcare Advisor. The Independent Healthcare Advisor remains the entity to be prosecuted for poor advice and not the medical scheme. Therefore, the Independent Healthcare Advisor only act as an agent of the member.

The contract doesn't automatically indicate control of one party over another. The specific stipulations contained in the contract will be the only determinant of control of one party over another. In addition, the CMS has enough power to regulate the entering of contracts between Independent Healthcare Intermediaries and medical schemes and can also provide the industry with model contracts to prevent any undue influence over the other. The CMS on 28 March 2018 published a circular 17 of 2018, titled: **"Final guidelines for the preparation of broker agreements in compliance with Section 65 of the Medical Schemes Act, No 131 of 1998 (the Act) and Regulation 28 published in terms of the Act"**[110] The following extract of this draft agreement supports the notion that the medical scheme does not have control over the Independent Healthcare Intermediaries:

- "The services rendered by the broker are separate and distinct from the services rendered by the Scheme or its administrator or any other party or person contracted by the Scheme and are in no way classed as joint administration services[111]"
- "Save as set out in this agreement, the broker shall have no authority to bind the Scheme in any way, to incur any liability or debt on behalf of the Scheme or in any way to pledge the credit of the Scheme or to make or alter or discharge any contracts or institute, defend or settle any proceedings involving the Scheme[112];"
- "Classique Medical Aid Consultants CC shall at all times remain an independent contractor and not an employee of the Scheme[113];"
- "The Scheme shall not be liable for any acts or omissions of Classique Medical Aid Consultants CC or of any agent, employee or representative of Classique Medical Aid Consultants CC[114];"
- "perform the Services in accordance with Annexure A and additional requirements of the Scheme, as communicated in writing from time to time and agreed upon by Classique Medical Aid consultants CC[115];
- "do anything that may cause anyone to believe that the Broker is acting as an agent of the Scheme[116];"
- Annexure A of the draft contract between a medical scheme and the Independent Healthcare Intermediary contain 43 specific duties and all these duties are performed towards the best interest of the member and there is not one stipulation to adhere to any instruction of the medical scheme[117].

Myth 3: Broker earn additional commission if ancillary products are sold and medical schemes with corporate links can better incentivise brokers to sell a bundle of products for higher commission beyond the legislated amount for medical schemes only

No person (medical scheme or administrator, or any person or entity) is allowed to pay an Independent Healthcare Advisor more than the legislated amounts. Any such payments that exceed the prescribed legislative amount will be a contravention of the Act and punitive sanctions can be imposed as determined from time to time by the Minister. Should these practices occur it does not necessitate legislative changes but rather require strict enforcement of the law[118].

110 http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

111 CMS Draft broker agreement, par3,2 , http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

112 CMS Draft broker agreement, par6,1, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

113 CMS Draft broker agreement, par6,3, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

114 CMS Draft broker agreement, par6,4, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

115 CMS Draft broker agreement, par7,1, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

116 CMS Draft broker agreement, par8,1, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

117 CMS Draft broker agreement, annexure A, http://www.medicalschemes.com/files/Circulars/Circular17Of2018.pdf

118 HMI Transcript, 3 March 2016, p223

The HMI heard allegations of where certain medical schemes and administrators acted outside the Act and where the RoMS put a stop to that[119]. This is correct and should always be enforced strictly. These examples were where Bestmed paid some brokers more than the legislated commission, Medihelp and Medshield[120] paid for some market research[121] and other contraventions by Sizwe and Hosmed[122][123]. Some of these contraventions combined with other governance failures also gave rise to the curatorship of some medical schemes and in some cases replacement of some or all the trustees of the medical schemes board of trustees. It should be noted that whilst larger medical schemes and medical schemes with corporate links are criticised for being able to pay Independent Healthcare Intermediaries more than the legislated amounts, smaller medical schemes in fact contravened the legislation. Therefore, the criticism against larger medical schemes seem to be hypocritical in some cases[124].

Loyalty or wellness programmes offered to members of medical schemes and to people who buy other financial products offered by Financial Service Providers such as Discovery[125], Momentum and Sanlam is not linked to only membership of the medical scheme[126]. In the case where the Independent Healthcare Advisor is also registered to sell other financial products and in fact provide advice in terms of the FAIS Act and sell those products it is impossible to determine if the wellness product was bought because of the medical scheme membership or because of the other financial products bought. In fact, the latter is more probable because some of these products offer integration benefits leading to heavily discounted fees for some of the financial products. However, due to the community rating environment medical schemes operate in, contributions to the medical scheme may not be discounted. Whilst some medical schemes criticise the existence of these products and the perceived value it provides to attract and retain members of the medical scheme, it is the same medical schemes that will also attack these products in that they lock consumers in and that consumers will find it more difficult to move from these products. Again, the criticism seems to be hypocritical[127].

The payment of commission to the independent healthcare advisor for the sale of any additional financial service products is regulated by different financial product legislation like the Pension Funds Act, the Short-term Insurance Act and the Long-term Insurance Act to name a few. There are specific requirements that need to be met before commission can be paid and this commission is for additional work the Independent Healthcare Advisor have done. It would be totally incorrect to say that this is a way for those entities to thwart the maximum commission scales as prescribed by the Medical Schemes Act. These products require specific advice, compliance and fit and proper standards and payment of the legislated commission for rendering these additional services must be separated from medical scheme commission. It is an accepted commercial reality that selling different products will diversify the entrepreneurs' income and that it is a way to increase its revenue. Most of the independent Healthcare Intermediaries are employed by a Financial Service Provider who is a registered company in terms of the Companies Act. It can be argued that companies have a legal obligation to its shareholders to reduce the risk within the business and one such way can be to diversify its income stream.

Myth 4: Brokers earn R2,2 billion and it is increasing. Members can save that money.

119 HMI Transcript, 3 March 2016, p223

120 HMI preliminary report 5 July 2018, p124, par 276

121 HMI preliminary report 5 July 2018, p122, par 275

122HMI preliminary report 5 July 2018, p125, par 286

123 HMI preliminary report 5 July 2018, p126, par 288

124 HMI preliminary report 5 July 2018, p122, par 276

125 HMI preliminary report 5 July 2018, p123, par 273

126 HMI preliminary report 5 July 2018, p139, par 370

127 HMI preliminary report 5 July 2018, p121, par 274

This myth consists of two sections. Firstly, it consists of the amount that the Independent Healthcare Advisor earns. The amount quoted always include distribution costs and marketing costs. **Therefore, the quantum quoted is incorrect.** However, the reason that the regulator and Minister of Health persist to inflate the commission level is not clear. The argument can be that it may be excessive. This is not the case. Secondly, the argument that then follows from the first part is that if this spend is taken away that members will be able to save money and that the money can be used for health benefits.

The first part of this myth is exactly that. The commission is 3% of the contribution to a maximum amount of R 90 excluding VAT. VAT cannot be the remuneration of the Independent Healthcare Advisor as it is not their money but belongs to SARS. The HMI heard evidence[128] that other financial service products carry higher levels of commission and in some cases up to 20%. In addition, commission for these products are not capped to a maximum amount. The graph below depicts the medical scheme commission against other non-healthcare expenses. It is clear from this graph that medical scheme commission increased at a slower pace than other non-healthcare expenses.

Commission is legislated at a maximum of 3% of the family contribution to a maximum cap as legislated from time to time. In 2016 it was R85[129] and currently it is R 90 (excl VAT). However, the average commission per family in 2016 was R 51[130]. In addition, it needs to be noted that this commission is the same whether the member is with medical scheme A, B or C[131]. This was specifically introduced to ensure that Independent Healthcare Advisors cannot be incentivised by medical schemes to place members with them[132].

Often commentators, including the CMS comment on the growth of broker fees. In this section we will share information that broker fees is not a cost driver in private medical schemes. The increase of commission can be explained by the following:

- Increase in contributions where commission is not at the capped maximum.
- Members upgrading their benefits or adding dependents and where the commission before was not at the capped maximum
- Increases in the capped maximum. As will be explained later is that the capped maximum did not increase with CPI.
- The primary reason is that due to the value that Independent Healthcare Advisors render more members make use of brokers. This is the primary reason.
- The main secondary reason is members that were previously not covered that is now covered. Medical scheme membership between 2006 to date with approximately 2,1 million members. This is an increase of more than 30%[133].

Figure 8: Growth in broker income

128 HMI preliminary report 5 July 2018, p122, par 267

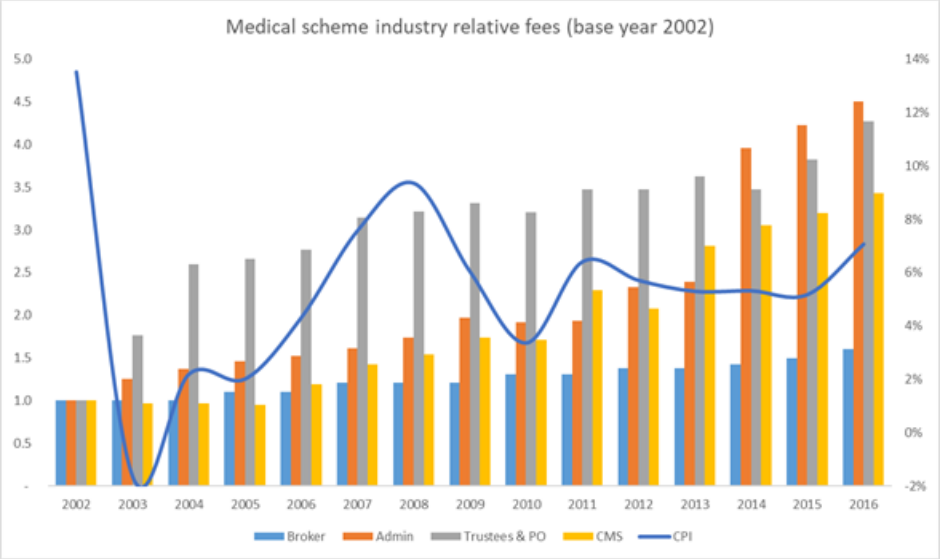
129 HMI transcript, 3 March 2016, p222

130 HMI transcript, 3 March 2016, p 209

131 HMI transcript, 3 March 2016, p255

132 HMI transcript, 3 March, p222

133 HMI transcript, 3 March 2016, 223



To understand the growth in non-healthcare costs, it is important that when looking at non-healthcare expenditure that all non-healthcare expenditure is normalised to a specific year and then illustrating the relative growth for each of the non-healthcare expenditure. The figure below depicts exactly this. 2002 was taken as the base year to which all expenses were normalised. From this figure all non-healthcare expenditure has far outgrown inflation whilst commission lags inflation. Therefore, commission can never be a cost driver of healthcare costs. The primary reason for this is the capping of the maximum commission.

The table below also show that the maximum amount an Independent Healthcare Advisor can earn was not increased every year and it did not keep pace with inflation[134].

Table 14: Growth of the Maximum Commission Cap vs Inflation

Year	Capped amount	Inflation	Amount if Cap was increased with inflation	Percentage Deviation
2000	R50	6,99%	R 53,5	6,54%
2001	R50	4,59%	R 55,96	10,65%
2002	R50	13,51%	R 63,52	21,29%
2003	R50	-1,63%	R 62,48	19,97%
2004	R50	2,2%	R 63,85	21,69%
2005	R55,18	2,02%	R 65,14	15,29%
2006	R55,18	4,32%	R 67,95	18,97%
2007	R60,70	7,57%	R 73,09	16,95%

134 Lizz Still, Healthcare in South Africa: 2018/19

2008	R60,70	9,35%	R 79,92	24,05%
2009	R60,70	6,04%	R 84,75	28,38%
2010	R65,65	3,37%	R 87,60	25,06%
2011	R65,65	6,41	R 93,22	29,58%
2012	R69	5,71	R 98,54	29,98%
2013	R69	5,3	R103,76	33,50%
2014	R71,07	5,32	R109,28	34,97%
2015	R75	5,18	R114,94	34,75%
2016	R80	7,07	R123,07	35%
2017	R85	4,5	R128,61	33,91%
2018	R90	4,08	R133,86	32,77%

From the facts provided above the only reasonable conclusion that can be made is that medical scheme commission payable to the Independent Healthcare Intermediary is not excessive.

The second part of debunking this myth relates to the incorrect hypothesis that the discounted contribution table would lead to a saving that can be attributed to enhancing medical scheme benefits. Please also consider the content of myth 1 when considering this portion regarding a proposed saving that will not be achieved and the moral harm that will be created. We have established that the quoted commission levels are incorrect and that it is not excessive. Further we have established that the saving per family will range between R 11,10 per month to R 90 per family per month and would average out at approximately R 60 per family per month. The mere quantum of the envisaged saving is insufficient to substantially increase health benefits. Further, the discount that the member will receive will be a contribution discount and it will not translate into additional healthcare benefits. In fact, due to the community rated environment that underpins our medical scheme legislation additional health benefits will not be permittable. In addition, the saving to the member is at most a temporary saving and this saving will increase administration expenditure. The HMI heard evidence in this regard.

The Minister of Health and the Minister of Justice[135] were quoted in the Sunday times on 12 August 2018 referring to a R 80 bn scam in relation to alleged fraudulent claims against the Department of Health. Only the money lost in this regard account for commission for more than 40 years. The problem of wastage of the healthcare spend lies somewhere else than with commission.

Shortcomings of the current regulatory environment

Classique Medical Aid Consultants CC identified specific shortcomings in the current regulatory framework and suggests the following possible solutions:

- **Inflation linked increases:** The current model does not impose a guaranteed increase in the maximum cap of commission payable. Although this may be socially desirable at an initial glance it is in fact not. The only way that Independent Healthcare Advisors can mitigate the loss of inflation linked increases in remuneration is to reduce the service levels. This is not desirable and should change to ensure a compulsory inflationary increase in the maximum cap of commission payable. We also propose that the backlog (Cap that did not keep track with inflation) be reduced to be aligned to inflation over a four-year period.

- **Model contracts:** Any possible concerns relating to Independent Healthcare Advisor contracts can be addressed in drafting of model contracts. The Registrar of Medical Schemes recently published model contracts between medical schemes and Independent Healthcare Advisors. The participation of stakeholders was disappointing primarily because the contract is seen as a regulatory compliance step. More attention can be given by stakeholders in this regard.

135 Qaanitah Hunter, "State attorneys' R80bn scam, Sunday Times 12 August 2018

- **Undesirable business practices:** The RoMS have the power to publish undesirable business practices. This may prove to be challenging as some of the decisions of the RoMS have been successfully appealed in our courts. This should not discourage the RoMS to publish undesirable business practices, providing it meets the legal muster required by our legal system.

- **Undesirable Business Practice Hot Line:** Classique medical Aid Consultants CC proposes that an Undesirable Business Practice Hot Line ("UBPHL") be established. It is proposed that this hot line should function in a similar manner to a fraud line. This line could be co-funded by the CMS and the industry. Consumers, medical schemes, Independent Healthcare Advisors, administrators, medical service providers and any other interested parties can lodge complaints with this UBPHL. This UBPHL will serve as an early warning or early detection of possible undesirable business practices, illegal activities and contraventions of the Medical Schemes Act and the FAIS Act. The CMS will be able to use this data from the UBPHL to regulate at source.

- **Publication of disputes:** The decisions relating to the resolution of complaints raised with the CMS are published on the CMS website. However, disputes raised with medical schemes remain secret. Therefore, consumers are less aware of their rights. Furthermore, consumers are not aware of the work Independent Healthcare Advisors do in securing successful outcomes on behalf of their clients. This will also strengthen the fact that the Independent Healthcare Advisor is not beholden to the medical scheme but stand in service of his clients alone. Therefore, Classique Medical Aid Consultants CC recommends that medical schemes be compelled to publish the outcome of dispute hearings on every medical scheme's web site. The format should be like that of the CMS.

- **Proper enforcement:** Classique Medical Aid Consultants CC believe the enforcement office of the CMS should be increased to allow for improved and visible enforcement. This will ensure that not only contraveners are brought to book, but that all stakeholders will respect the letter and spirit of the Medical Schemes Act. Consumers will be the beneficiary of a trusted enforcement capacity by the regulator[136].

- **Statutory apprenticeship:** The Medical Schemes Act does not have any provision relating to a minimum level of competence. Applicants with more than two years' experience are registered as healthcare advisers and those with less experience are registered as apprentice brokers. There is, however, no formal apprenticeship or supervision. It is recommended that all new applicants be subjected to an apprenticeship of two years. It is further suggested that the apprentice complete a portfolio of evidence that must be signed off by a supervising independent healthcare intermediary. Further, it is suggested that the apprentice broker be subjected to a "board exam" before such an apprentice is converted into a full broker. Finally, it is suggested that an apprentice be prohibited from providing advice without supervision by the overseeing broker.

- **Minimum qualifications:** The only requirement to become a medical scheme broker is that the applicant must have a matric qualification. The FAIS Act requires specific qualifications but there is no prescription for a specific industry qualification. Classique Medical Aid Consultants CC believe a healthcare specific qualification at an NQF level 5 must be made compulsory for all new entrants and that existing brokers must be given 3 years to obtain such a qualification.

Conclusion

On the 29 November 2013 the Competition Commission ('the Commission') decided to conduct an inquiry into the Private Healthcare Market ('HMI'). This was done at the request of the honourable Minister of Health to better

136 HMI transcript 3 March 2016, p223

understand the reasons of cost drivers in the private healthcare market and to identify anti-competitive practices. The primary motive of the honourable Minister was to better protect the interest of the members of private medical schemes and to eventually adhere to the Constitutional Mandate of providing every citizen with access to quality healthcare. The Commission followed a comprehensive four-phased approach and after a thorough investigation published its preliminary report on the 5th July 2018.

All stakeholders, including the public, have until the 7th September 2018 to comment on the report where after the Commission is expected to publish a final report and recommendations by the 30th November 2018. There is a significant risk that the regulatory environment being created through the legislative amendment process (Medical Scheme Amendment Bill- "MSAB") currently underway could conflict with the lessons learned during the HMI's work, which will only be fully apparent on the release of its final report. We requested the honourable Minister to consider that a far greater value could be added if the final HMI findings and recommendations are embraced and incorporated as the foundation for the amendments in the creation of a fresh approach to healthcare for the country. This will provide the honourable Minister with an ideal opportunity to strengthen legislation with the full benefit of wisdom garnered during the lengthy and expensive inquiry and the best chance we have of making informed decisions that will shape the future of healthcare in South Africa for all.

The Constitution and the Promotion of Administrative Justice Act (PAJA) prescribe that any public process, which include amendments to legislation, needs to be fair, reasonable and rational. We are concerned that proceeding with the MSAB before the final HMI report may be questioned in terms of fairness, reasonableness and rationality. Therefore, we respectfully requested the honourable Minister to temporally withdrew the MSAB until the final HMI report and recommendations are published. We respectfully suggest that if the MSAB is redrafted after publication of the final HMI report and recommendations the quality of legislative amendments will be improved. We respectfully concluded that through this thorough, arduous process the honourable Minister will discharge his duty to the public in a constitutional, transparent and responsible manner where due process is not only done but is seen to be done.

We have provided evidence that:

- Dual regulation is not conducive to maximum client protection. It is our considered opinion that only the FSCA should regulate market conduct. The intermediary categorisation and remuneration should be aligned to the FSCA and Treasury's processes.
- The Independent Healthcare advisor adds value to the industry and consumers.
- The current opt-in and opt-out system offer maximum consumer protection.
- Discounted contribution tables will harm consumers.
- The current commission model is preferred by consumers.

We have also made suggestions on how the Independent Healthcare Advisory model can be improved, and how the industry can further be professionalised to the benefit of the consumer.

The discounted rate table proposed in the Medical Scheme Amendment Bill is problematic and cannot be supported and should not proceed. The current system where Independent Healthcare Advisors are used creates no dualistic or competing or countervailing power. Therefore, an Independent Healthcare Advisor must convince existing clients or prospective clients that its services are superior to that of other Independent Healthcare Advisors. Price won't play a role because commission is standardised, only value demonstrated will be a deciding factor. In addition, for Independent Healthcare Advisors, to earn commission they must demonstrate value to existing or prospective clients to the extent that making use of the services of an Independent Healthcare Advisor is more valuable than going directly to a medical scheme. Price won't play a role because commission is standardised and paid if using an Independent Healthcare Advisor or not, only value demonstrated will be a deciding factor. Consumer harm is reduced by standardising and community rating commission. If the consumer will be afforded a discount if making use of tied agents or going directly to a medical scheme, such a policy will lead to exclusionary practices. Based on price the commission-based services of Independent Healthcare

Intermediary will become an exclusionary practice[137]. A particularly difficult area is exclusionary pricing. Competition policy seeks to protect competition and thereby, inter alia, to deliver lower prices to consumers. However, sometimes lower prices lead to harmful exclusionary outcomes where, for example, they deliver a very good deal to (a certain group of) consumers in the short term but substantially reducing competition in the long term and creating more harm than the benefits of reducing price. A discounted commission model will eventually lead to a fee-based service model where, contrary to the current system, most members will not be able to afford fee-based services. A simplistic way of addressing consumer harm is to argue that the existing system is more expensive and that a discounted model will lead to consumer benefits due to the cost saving. At best this line of argument will just defer the same question of consumer harm to a later stage. Exclusionary practices itself is a harm to consumers[138]. In practical sense more than 90% of members make use of the services of an Independent Financial Advisor. This is for the consumer (family) on average R 65 pm but can be as little as R 11,10 and maximum R 90. This gives the consumer access to unlimited advice and intermediary services as defined by the FAIS General Code of Conduct[139]. However, in a fee-based model of say R 750 per hour a family will be able to buy less than 5 minutes of an Independent Healthcare Advisors time per month with the saving achieved. Alternatively, only one-third of members will be able to afford the services of the Independent Healthcare Intermediary. The loss to the consumer far exceeds the possible gain of a mere, on average R60 pm saving. To infer exclusionary behaviour from harm to consumers is not the answer for the following two reasons[140]:

- Firstly, this simply assumes away the problem. If the issue is whether consumers will be harmed in the future from a low price or discount set today, we cannot observe harm to consumers and so the "test" has no power.
- Secondly, harm to consumers need not be caused by exclusionary competition.

Therefore, the proposed discounted contribution tables, introduces exclusionary and anti-competitive practices. This proposal of discounted contribution tables is entirely arbitrary and contravenes the provisions of section 9 of the Constitution[141] of the Republic of South Africa, 1996 ("the Constitution") which provides for the right to equality. In this regard, according to the Constitutional Court in Prinsloo v Van der Linde 1997 (3) SA 1012, at paragraph 25 –

> "The constitutional state is expected to act in a rational manner. It should not regulate in an arbitrary manner or manifest naked preferences that serve no legitimate governmental purpose, for that would be inconsistent with the rule of law and the fundamental premises of the constitutional state. The purpose of this aspect of equality is, therefore, to ensure that the state is bound to function in a rational manner. This has been said to promote the need for governmental action to relate to a defensible vision of the public good, as well as to enhance the coherence and integrity of legislation

We are still of the opinion that it would be prudent for the Honourable Minister of Health to temporarily withdrew the Medical Schemes Amendment bill till the finalisation of the HMI in November 2018 we have provided detailed comment in annexure C to this submission. The comment contained in the annexures should be read with the main document.

Classique Medical Aid Consultants CC is prepared to meet with the honourable Minister to discuss our comment and jointly find a workable solution for the private healthcare industry.

137 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

138 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

139 FAIS General Code of Conduct

140 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

141 Constitutional Court in Prinsloo v Van der Linde 1997 (3) SA 1012, at paragraph 25

Annexure A: FAIS General Code of Conduct vs CMS Model Broker Contract

CMS Model Agreement between Broker and a Medical Scheme versus the FAIS General Code of Conduct

In this annexure we only focus on 3 key components affecting the rights of consumers namely recordkeeping, advice and disclosure. It is clear from this comparison that the FAIS General Code of Conduct provide substantially more comprehensive protection for the consumer.

CMS Model Agreement between Broker and a Medical Scheme	FAIS General Code of Conduct	Comment
Recordkeeping		
The model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme place an obligation on the Intermediary to keep certain records[142]. Par 1,12 of Annexure A[143] of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme place an obligation on the Intermediary to keep records of the enrolment of members. Unfortunately, what is meant with this type of recordkeeping is vague.	The FAIS General Code of Conduct place far more emphasis on recordkeeping and require substantially more recordkeeping requirements to be met. The following sections of the FAIS General Code of Conduct[144] are relevant: Paragraphs; 3(2) (a) , (i), (ii) and (iii), 3 (2) (b),(c) and (d), Par 8, Par 9 (1) (a), (b), (c) and (2)	The danger is the arbitrage between the two regulatory bodies. The CMS focussed more on the form of record keeping whereas the FSCA focussed on the form as well as the substance. Par 8 of the FAIS General Code of Conduct specifically address the content of the types of advice that should be recorded. Complying with the CMS requirements could mean that an intermediary comply with keeping inappropriate records and records of poor advice, whereas the FSCA require a qualitative approach to recordkeeping.
Advice		
Par 1,1 of Annexure A of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme place an obligation on the Intermediary to provide "Best Advice" and to act in the best interest of the member and the medical scheme[145]. Par 1,14, 1,15 and 1,16 of Annexure A of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme require from the Intermediary to do a needs analysis, present options, benchmark solution	Par 1, 2 and par 8 of the FAIS General Code of Conduct [149]deals with advice provided. Par 1 deals with the requirement that advice must be factually correct and that specific aspects should be disclosed to the client. Par 2 encapsulates the ethos of the FAIS General Code of Conduct. It states as follows: "A provider must at all times render financial services honestly, fairly, with due skill, care and	The FAIS Act and the FAIS General Code of Conduct are in direct conflict with each other on two key areas, namely; Firstly, the FAIS Act do not require best advice. In fact, the General Code of Conduct only require suitable advice and read with par 2 it would mean advice that is in the interest of the member and no other person. Best advice cannot be defined and is open to interpretation. It is for this reason that the General Code of Conduct in par 8 rather propose an

142 Model Intermediary agreement published by the CMS, par 7,3

143 Model Intermediary agreement published by the CMS, Annexure A, par 1,12

144 FAIS General Code of Conduct, par 3,8 & 9

145 Model Intermediary agreement published by the CMS, Annexure A, par 1,1

149 FAIS General Code of Conduct, par 1,2& 8

offered to prospective clients[146]. Where the CMS require the advice to be only applicable to prospective clients FAIS requires it to be applicable every time advice or intermediary services are rendered. The CMS only require that advice to be recorded according to par 1,17 of Annexure A of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme when the member accepts the advice[147]. In contrast the FAIS General code of conduct also require specific recordkeeping when the member or client does not accept the advice[148].	diligence, and in the interests of clients and the integrity of the financial services industry." Par 8 deals with the steps of providing suitable advice.	internationally recognised 6-step process[150]. Secondly, the CMS require the intermediary to act in the best interest of the member and the medical scheme. The FAIS General code of conduct and specifically par 2 is in direct conflict with the CMS requirement. The interest of the member and the interest of the medical scheme is mutually exclusive. The intermediary can only serve the interest of the member of a medical scheme and no one else. The FAIS Act also places this obligation on the intermediary.
Disclosure		
Par 7 or any of the paragraphs of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme is silent on disclosure.[151] Par 1,3 of Annexure A of the model agreement proposed by the CMS between the Independent Healthcare Intermediary and the medical scheme require four types of disclosure; namely[152]: • the name of the Scheme which he/she represents in terms in this agreement and the rules of such Scheme or explanation thereof; • the registered contributions for the cover which the member has chosen; • the nature of the services he/she renders; and • the compensation payable to	The FAIS General Code of Conduct in par 3 require detail to be disclosed regarding the Financial Service provider rendering the service and the contracting party. This would include complaints procedures[153]. Par 7 of the FAIS General Code of Conduct compel the Intermediary to disclose detailed product information as well as the implications of the products or change to products[154]. Par 8 of the FAIS General Code of Conduct compel the Intermediary to disclose the contribution all fee and commission[155].	The disclosure requirements contained in the FAIS General Code of Conduct is far more comprehensive and protect the healthcare consumer far more than what is required by the CMS.

146 Model Intermediary agreement published by the CMS, Annexure A, par 1,14,15 and 16

147 Model Intermediary agreement published by the CMS, Annexure A, par 1,17

148 FAIS General Code of Conduct, par 8 (4) (b)

150 FPI 6-step process

151 Model Intermediary agreement published by the CMS

152 Model Intermediary agreement published by the CMS, Annexure A, par 1,3

153 FAIS General Code of Conduct, par 3

154 FAIS General Code of Conduct, par 7

155 FAIS General Code of Conduct, par 8

him/her;	Par 9 of the FAIS General Code of Conduct compel the Intermediary to provide the client with a record of advice[156].	

156 FAIS General Code of Conduct, par 9

Annexure B: Detailed feedback on the HMI draft report in relation to Brokers

HMI REPORT REFERENCE TO BROKERS

Theory of harm		**Regulation**	**Self-regulation**	**Additional steps that can be taken**
MARKET POWER AND DISTORTIONS IN HEALTHCARE FINANCING	The relationship between brokers, medical schemes and consumers.	We have dealt with this extensively in terms of the commission system that we believe is fair. See our comment on the HMI pages 69 and 73	The services provided by Independent Healthcare Advisors far outweigh the services as described by the CMS Model Broker contract or the FAIS General Code of Conduct. The role and value of the Independent Healthcare Advisor is extensively discussed in the main document of our submission.	Despite the best efforts of the CMS and the Independent Healthcare Advisors it is still possible that some consumers don't realise the services that they receive is from their appointed Independent Healthcare Advisor. This is notwithstanding the active opt-in system that exists. Therefore, we suggest that the detail of the appointed Independent Healthcare Advisor is contained on every correspondence the medical scheme sends to the member. This is an example of an ex post remedy as proposed by Nicolas Petit to reduce possible consumer harm.[157]

Page nr	HMI	Classique comment
37	24. Brokers advise and guide consumers and employers in selecting private health insurance cover. They provide consumers and/or employers with information on benefits and services offered by medical scheme and/ or health insurers. There are independent brokers that provide services for multiple schemes or tied brokers that are contracted to a particular scheme. Brokers must be accredited by the CMS and licensed by the Financial Services Board (FSB).	The role and value of the Independent Healthcare Advisor is extensively discussed in the main document of our submission. However, we would like to emphasise that Independent Healthcare Advisors also act on their client's behalf to ensure that the rights of their clients are protected when and where medical schemes infringe on this. We have provided ample examples of this. In addition to a mere noting of the dual regulation of the broker we have also in the main document of our submission explained why the dual regulation is problematic and why market conduct should only be regulated by the FSCA and not the CMS.
58	135. Brokers advise individuals and employers about the various healthcare products they	This is correct. However, where members move from one medical scheme to another and when they

157 NICOLAS PETIT, UNIVERSITYOF LIEGE(ULG), The OligopolyProblem: BeyondMergerLaw, ACLE SEMINAR, 14 MARCH 2011, https://antitrustlair.files.wordpress.com/2011/03/presentation-acle-14-march-2011-n-petit.pdf

	support including assisting them in choosing between schemes and benefit options.	change options Independent Healthcare Advisors also identify the risks and possible penalties that members can be exposed to. In order to give effect to the General code of conduct for FAIS Independent Healthcare Advisors need to remain fit and proper, maintain specific competency levels and do a thorough needs analysis amongst a myriad of other obligations.
58	In the case of brokers serving individuals, product sales are commission-driven. Product providers (insurers, etc.) set the commissions that brokers receive for advising on and selling products. Brokers may only receive a capped amount per policy. This is set as a percentage of the policy cost unless it reaches a certain maximum at which point they may receive a Gazetted rand value per person per month (R85 plus VAT from January 2017). Brokers also earn additional income through the sale of related insurance and wellness products.	This paragraph is not correct. All medical scheme products are commission driven whether sold to an individual or to an employer group or to the employees of an employer group. It is incorrect to state that Insurers or medical schemes set the commission levels. Medical scheme commission is legislated at 3% of the contribution to an absolute maximum of a caped amount as determined by the Minister of Health. It is important to note that in our main document we argue that the capped amount did not keep up with inflation. In addition, expenses of administrators and even the Council's own fees far outpace the growth in the cap of broker commission.
59	Table 3.7 shows that although total expenditure on brokers amounts to a relatively small part of total medical schemes' non-health costs (ranging between 2.4% and 2.9% of schemes' gross contribution income), there has been a steady rise in broker fees pbpa between 2005 and 2016 (Table 3.7). The role of brokers in reducing information symmetries and in influencing the decisions of consumers is discussed in detail in chapter 6.	The reference to commission is incorrect as it also contains marketing and distribution costs. However, the commission did increase, and we have reported on it extensively in the main document. It is important to note that in our main document we argue that the capped amount did not keep up with inflation. In addition, expenses of administrators and even the Council's own fees far outpace the growth in the cap of broker commission.
64	148. Non-health expenditure remained fairly stable for most of the period 2005 – 2016 but we do note that open schemes have higher non-health costs than restricted schemes. Though expenditure on brokers equates to a relatively small part of total medical schemes non-health costs, we note that there has been a steady rise in broker fees pbpa between 2005 and 2016.	Please see comment above as well as a thorough analysis of broker commission and other non-healthcare costs in our main document of our submission.
69	Theory of harm: **MARKET POWER AND DISTORTIONS IN HEALTHCARE FINANCING**: The relationship between brokers, medical schemes and consumers.	The theory of harm is not an exact science nor easy. Even if consumer harm can be measured accurately, the trading of gains in profits is even more challenging. [158] The current system where Independent Healthcare Advisors are used creates no dualistic or competing

158 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 145

		or countervailing power. Therefore, an Independent Healthcare Advisor must convince existing clients or prospective clients that its services are superior to that of other Independent Healthcare Advisors. Price won't play a role because commission is standardised, only value demonstrated will be a deciding factor. In addition, the Independent Healthcare Advisor, to earn commission must demonstrate value to existing or prospective clients to the extent that making use of the services of an Independent Healthcare Advisor is more valuable than going directly to a medical scheme. Price won't play a role because commission is standardised and paid if using an Independent Healthcare Advisor or not, only value demonstrated will be a deciding factor. Consumer harm is reduced by standardising and community rating commission. If the consumer will be afforded a discount if making use of tied agents or going directly to a medical scheme, such a policy will lead to exclusionary practices. Based on price the commission-based services of Independent Healthcare Intermediary will be excluded effects[159]. A particularly difficult area is exclusionary pricing. Competition policy seeks to protect competition and thereby, inter alia, to deliver lower prices to consumers. However, sometimes lower prices lead to harmful exclusionary outcomes where, for example, they deliver a very good deal to (a certain group of) consumers in the short term but substantially reducing competition in the long term and creating more harm than the benefits of reducing price. A discounted commission model will eventually lead to a fee-based service model where, contrary to the current system, most members will not be able to afford fee-based services. A simplistic way of addressing consumer harm is to argue that the existing system is more expensive and that a discounted model will lead to consumer benefits due to the cost saving. At best this line of argument will just defer the same question of consumer harm to a later stage. Exclusionary practices itself is a harm to consumers[160]. In practical sense more than 90% of members make use of the services of an Independent Financial Advisor. This is for the consumer (family) on average R 65 pm but can be as little as R 11,10 and maximum R 90. This gives the consumer

159 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

160 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

		access to unlimited advice and intermediary services as defined by the FAIS General Code of Conduct[161]. However, in a fee-based model of say R 750 per hour a family will be able to buy less than 6 minutes of an Independent Healthcare Advisors time with the saving achieved. Alternatively, only one-third of members will be able to afford the services of the Independent Healthcare Intermediary. The loss to the consumer far exceeds the possible gain of a mere, on average R65 pm saving. To infer exclusionary behaviour from harm to consumers is not the answer for the following two reasons[162]: • Firstly, this simply assumes away the problem. If the issue is whether consumers will be harmed in the future from a low price or discount set today, we cannot observe harm to consumers and so the "test" has no power. • Secondly, harm to consumers need not be caused by exclusionary competition. Therefore, we recommend that the HMI consider harm to competition and consumers together, specifically where exclusionary behaviour will be created by discounted commission. Nicolas Petit argues that in some cases the trade-off for competition regulators is to provide a workable ex post remedy against certain types of consumer harm.[163] Petit quoted Shavell in stating that most enforcement systems rely on a fluctuating balance of ex ante/ex post interventions.
73	69. Consumers' responsiveness to relative changes in prices and quality acts as a *competitive constraint* to suppliers with market power that attempt to raise prices or reduce quality and service. A market inquiry therefore needs to investigate how consumers can and will react and to what degree it may represent *countervailing power* in cases of a possible attempt to abuse market power by a supplier or group of suppliers. Also, in the case of healthcare, the role of agents such as brokers and GPs to support consumer's choice must be	The current model regarding the use of Independent Healthcare Advisors is efficient and manages possible conflicts of interest well. The system briefly works as follows: • Member can join medical schemes by using an Independent Healthcare Advisor or by joining or interacting with a medical scheme without an Independent Healthcare Advisor. Members have the power. • Independent Healthcare Advisors can only earn commission if explicitly appointed by

161 FAIS General Code of Conduct

162 Loyola Consumer Law Review, Volume 20, Issue 2 , The Role of a Consumer Harm Test in Competition Policy, 2008, page 146

163 NICOLAS PETIT, UNIVERSITYOF LIEGE(ULG), The OligopolyProblem: BeyondMergerLaw, ACLE SEMINAR, 14 MARCH 2011, https://antitrustlair.files.wordpress.com/2011/03/presentation-acle-14-march-2011-n-petit.pdf

	understood, including possible agency problems that might distort competition.	a member or employer on behalf of its employees. Medical schemes may not allocate brokers to members. Members have the power. • Members may at any stage withdraw the appointment of an Independent Healthcare Advisor and from that moment the medical scheme must stop paying the Independent Healthcare Advisor. Medical schemes have no discretion in this regard. Members have the power. The current system where Independent Healthcare Advisors are used creates no dualistic or competing or countervailing power. The power only exists in the hands of the member. However, a discounted model will create a *countervailing power* where medical schemes and their tied agents will be in direct competition with their distribution channel, the Independent Healthcare Intermediary. This *countervailing power* will create an anti-competitive landscape only benefitting medical schemes and benefitting larger medical schemes more than smaller medical schemes.
77	7.5. The HMI sought to understand the role of brokers in driving competition between medical schemes, and how they aid the consumer to select appropriate healthcare cover.	It is not really the role of the Independent Healthcare Advisor to drive competition between medical schemes. Independent Healthcare Advisors are employed by their clients and must serve the interest of their clients. Therefore, advice that complies with the FAIS Act, must be adequate and appropriate for the need of the client[164]. This means that the Independent Healthcare Advisor does not have the interest of the medical scheme at heart but that of his client. Medical schemes must demonstrate that they can fulfil the need of the Independent Healthcare Advisor's client. This indirectly create an environment for fair competition.
85	47. Finally medical schemes explained that their market is broker driven, and if the medical scheme does not have strong relationships with brokers, it will not grow. Medical schemes with corporate links have the ability to better incentivise brokers to sell a bundle of products for higher commission beyond the legislated amount for medical schemes only.	This is factually untrue. No medical scheme can pay any amount that exceeds the legislated commission. Any such payment will be illegal and an offence in terms of the Medical Schemes Act. Please also consider Myth 3 in our main document of our submission.
86	53. New entrants have a branding and marketing disadvantage compared to incumbents. Large incumbents have, over the years, invested significantly into developing	Brand awareness and the benefits of an established brand compared to incumbents have to be recognised as a reality. However, this does not

164 FAIS General Code of Conduct, Part III, par 3 (1) (iii)

	strong brands through various marketing tools such as wellness and loyalty programmes. They have long standing relationships with independent brokers and have established their own tied broker networks. They have also benefited from advertising by the group as a whole. DHMS and Momentum Health, for example, benefit from brand recognition and advertising from the Discovery and MMI groups respectively. New entrants, particularly those not linked to a group of companies, will have to come up with unique ways to promote and advertise their product. Technology and social media may be able to assist them with reaching out to potential clients, but even so, they will be at a disadvantage. The role and impact of wellness programmes and brokers are discussed in more detail in the sections titled, "The Role of brokers", and "Loyalty and wellness programmes".	differ from any other commercial operation or industry. It needs to be understood that when Discovery entered the market Metropolitan health, Sanlam Health and Fedhealth were strong brands. However, administrative challenges at Sanlam Health and Fedhealth gave rise to rapid growth for Discovery. They competed and seized the opportunity presented in the market. Momentum Health was also a new entrant a few years ago and they grew the medical scheme from an insignificant number to the third largest medical scheme. Umvuzo health substantially outperform ThebeMed. Both are relatively new medical schemes without the backing of an insurance company and a loyalty programme. GEMS also grew in a short space of time to the second largest medical scheme without the backing of an insurance company or a loyalty programme. Here the real trigger for growth was the subsidy policy that the employer applied to stimulate movement to GEMS. Loyalty and wellness programmes cannot and is not the main reason of dominance. Please also consider Myth 3 in our main document of our submission.
96	106. Employer groups without their own medical scheme select one or a handful of preferred open medical scheme(s) that their employees must join as a condition of employment. Open schemes compete for these employer groups. About 50% to 70% of open medical scheme members join through their employer group. Where employers offer only one medical scheme, their employees have no choice in medical scheme membership, but can only select their preferred benefit option. Brokers explained that employers are increasingly allowing employees to select between more than one medical scheme in what is known as split risk.	This observation made by the HMI may create a perception that Employers choose one or more medical schemes and then the broker get involved thereafter serving the interest of the participating medical schemes. If this is the case it would be incorrect. Independent Healthcare Advisors usually advise employers on which medical scheme or schemes to offer to their employees. Independent Healthcare Advisors then on instruction or by mandate from the employer advise employees of their choices and assist them to make informed choices as prescribed by the FAIS Act[165].
98	117. The lack of a uniform way of classifying benefit options across the industry creates confusion for members. The CMS, health actuaries, brokers and medical scheme administrators all have varied ways of	This observation made by the HMI consist of two parts namely firstly, the classification of benefit options and secondly, the members understanding of what they purchased.

165 FAIS General Code of Conduct, Part III, par 3 (1) (iii)

	classifying benefit options. Consequently, members only really become aware of the details of the products that they purchased (ie the particular medical scheme and benefit option) when they try to claim and usually when the cover is partially paid or not paid at all.	We must respectfully differ from the HMI on the fact that the listed stakeholders classify benefit options differently. We would argue exactly the opposite that between the stakeholders there is a common understanding of the classification of benefits. Further, our opinion is that this consistency does not create any asymmetry of information and does not confuse consumers. Consumers know that Hospital plans only cover hospital events and savings plans cover hospitalisation and some day-to-day expenses up to what is available in the savings account. The classification does not create any confusion. The second part relates to consumers only becoming aware of what is covered and what not at claim status. This is correct. However, these phenomena are not only restricted to medical schemes but the whole insurance industry. Further, this asymmetry of information also exists globally. In this regard consumer have access to the brochures, benefit statements, rules of the medical scheme and their broker. In this regard the FAIS Ombud and our courts have also emphasised the members role in ensuring that they are adequately covered. The CMS annual report every year indicate a huge number of complaint where members don't have sufficient cover because the member have not pre-authorised. Whilst medical schemes, the regulator and Independent Healthcare Advisors can always improve the education of members of medical schemes members have to also bear responsibility. However, the member may need a hernia operation. There are various methods how the procedure can be done and various ways in which the Hernia can be repaired. This is usually contained in the medical scheme protocols. Although, regulation 15 H (b) compel medical schemes to make this protocol (Treatment method) available to members upon request medical schemes are reluctant to do so. Further when this is done the jargon or terminology also is beyond the general members understanding. The complexity of different procedures and the protocols related to those procedures are too complex to be contained in the rules of a medical scheme or in brochures. A good example is the Algorithms contained in Annexure A of the Regulations promulgated in terms of the Medical Schemes Act

110	185. Some stakeholders criticized AGMs as ineffective as attendance and participation are usually low. The CMS has suggested that medical schemes should actively mobilise members to attend AGMs, through among other things, negotiating with employers to release employees for purposes of attendance and requiring brokers as part of their ongoing service obligations to notify, remind and encourage members to participate in AGMs.	Although, Independent Healthcare Intermediaries agree that AGM's are important and that members should attend this is not a function prescribed by the FAIS Act nor the Medical Schemes Act. This is a good example of regulatory scope creep as addressed in our main document of our submission in the section titled: "**The Independent Healthcare Advisor, Social Solidarity & Regulation as a "free service"."** Bamber[166] refer to this as typical examples where financial products should have a base commission because the consumer expects this as a free service and a commercial value can't be placed on this service.
113	Elections are one of the more direct ways in which members can participate in the medical scheme. Given the important role trustees play in the governance and performance of medical schemes, it is crucial that their appointment is fair, credible and transparent. Stakeholders are concerned that the process of electing trustees in some instances is not always fair and transparent as there are features of administrator capture, manipulation and undue influence. The CMS investigated cases where managing directors of administrators allegedly solicited votes with brokers. The CMS stated that medical schemes often do not provide members with timely and adequate information on the election process to enable them to make informed decisions.	Although, we agree to the active participation of members at AGM's, the Independent Healthcare Advisor cannot condone undesirable business practices as mentioned. We are supportive of regulatory enforcement in this regard to avoid this to happen. The fact that the CMS was aware of this and used their regulatory muster to put an end to this is indicative that the regulator is regulating appropriately.
115	As discussed in the partial regulation section, consumers wishing to join a medical scheme face a daunting task of choosing between 22 open medical schemes and 185 benefit options that are neither standardised nor comparable. Brokers, in return for a monthly commission, provide advice to their clients at the time they wish to join a medical scheme or health insurer and for on-going advice and assistance after their clients have purchased health cover. Corporate brokers may also provide employer groups with additional services, such as actuarial and marketing services, for extra fees.	We fully support this observation of the HMI. This clearly illustrate the relationship between the member and the broker. We just want to add that these services are rendered in compliance to the FAIS General Code of Conduct.[167]
115	225. Through advising clients on their medical scheme selection, brokers channel demand and therefore influence competition amongst healthcare funders. The inquiry is therefore interested in the role brokers play in influencing how medical schemes compete for	We agree to a large extent with the content of this paragraph. However, we do not agree that some medical schemes can legally pay brokers more than what is legislated. That will be contrary to the Medical Schemes Act and will be an offence in terms of the Act.

166 Bamber, Falkena, Llewellyn, Store, Financial Regulation in South Africa 2001

167 BN 80 of 2003

	members. The inquiry has heard evidence that medical schemes and administrators need a close relationship with brokers in order to expand. Some medical schemes developed strong relationships with brokers during the time when regulations pertaining to brokers were not onerous. At the time, some medical schemes and administrators recognised the important role brokers play in channelling demand and invested in this relationship. These medical schemes continue to have good relationships with brokers today. The inquiry is therefore interested in whether the incentives of brokers align with the medical scheme/ administrator or with the interests of the consumers'. In this regard, several allegations related to how brokers may negatively influence competition between medical schemes have been made.	Over the last two decades various medical schemes did in fact attempted to pay brokers additional money in contravention of the Medical Schemes Act. Evidence was provided to the HMI of these contraventions. However, the fact that these practices are public and that the CMS Acted on those that thwart the Medical Schemes Act indicate that the market is efficient to expose these undesirable contraventions of the Medical Schemes Act and that the regulatory muster of the CMS did not fail. We have dealt with these types of allegations in our main document. Please see the sections that deal with **myth 1, 2 and 3.**
115	227. When the Medical Schemes Act, 1998 (Act No. 131 of 1998) (MSA) came into full effect in 2000, it legalised brokers and introduced requirements to accredit brokers who were servicing medical scheme members. It also made brokers' commission structure transparent and capped monthly commission from medical schemes.	We agree with this observation of the HMI. It is maybe important to understand the process and reasoning behind the current regulatory framework. This is explained in detail in our main document. Please see the sections that deal with **myth 1.** The one benefit of the current structure is the transparency that it provides regarding commission and that broker commission can be quantifiable. Even though the structure is transparent Independent financial Advisers must disclose the commission to their clients[168].
116	228. Other changes in the financial services industry meant that brokers could no longer earn large upfront commission for health insurance products. All licensed brokers must also comply with the Financial Service Board's (FSB) Financial Advisory and Intermediary Services (FAIS) General Code of Conduct (Board Notice 80 of 2003) and medical scheme brokers must be accredited in terms of the MSA. These brokers are thus regulated by both the FSB and the CMS.	We agree with this observation of the HMI. This is addressed in detail in our main document of our submission in the sections titled: "**The challenges of dual regulation"** and **"Myth 2"**
116	229. Brokers who lose accreditation in terms of the MSA automatically lose their licence in terms of the FAIS Act and vice versa. The inquiry heard that some medical schemes and their administrators are more vigilant than others in verifying the validity of brokers' licences. These medical schemes halt any commission payment to brokers who lose their licences. Some medical schemes, on the other hand, do not verify brokers' licences regularly	This practice will be a contravention of the Medical Schemes Act and as such is an offence in terms of the Act. In this regard the regulatory muster should not fail the consumer. This is addressed in detail in our main document of our submission in the section titled: "**The challenges of dual regulation"**

168 FAIS General Code of Conduct, Part VI, par 7 (1) (c) (vi)

	and pay the brokers' commission regardless of the status of the licences.	
116	230. Stakeholders submit that brokers potentially play an important role in reducing search costs and the complexity of products on offer and, in doing so, improve consumer welfare, grow medical schemes, and strengthen competition. (Disc & Profmed)	Independent Healthcare Advisers add huge value to medical scheme members. This is addressed in detail in our main document of our submission in the sections titled: "**Role of the Independent Healthcare Advisor" a**nd **"The Undisputed value of the Independent Healthcare Advisor"**
116	231. Some stakeholders are of the view that brokers can influence individual members as well as employer groups to move to a particular medical scheme. Not all open medical schemes use brokers. For instance, Cape Medical Plan does not contract with brokers because broker fees increase non-healthcare expenditure. Cape Medical Plan believes that this decision resulted in a decline in its membership from close to 30 000 members in the 1990s to under 6 000 members in 2014.	Independent Healthcare Advisers fulfilling their obligations in terms of the FAIS Act will provide the member with advice and if the member accept that advice the Independent Healthcare Adviser is obliged to implement the decision of the client[169]. The FAIS General Code of Conduct also prescribe the actions the Independent Healthcare Adviser where the client does not follow the advice of the Independent Healthcare Adviser[170]. Currently, there are open medical schemes that choose not to remunerate brokers. These medical schemes struggle for new young membership and struggle to keep up with the needs of consumers, due to less constructive feedback from Independent Healthcare Advisors. However, we respect their choice not to make use of from Independent Healthcare Advisors. Successful medical schemes have embraced from Independent Healthcare Advisors, and consumers reap the rewards on the feedback given to medical schemes by from Independent Healthcare Advisors to ensure products remain relevant for the constantly changing, cost conscious, and technological advancing environment. The current environment shows clear evidence that successful medical schemes and consumers see more value in the advisor model than the other way around, and consumers receive direct value in relevant benefit enhancements on medical scheme plans on an annual basis from proactive feedback between medical schemes and from Independent Healthcare Advisors. Unfortunately, this robust but efficient relationship between Independent Healthcare Advisors, medical schemes and consumers are often criticised by those medical schemes not making use of Independent Healthcare Advisors. It was their choice not to make use of Independent Healthcare

169 FAIS General Code of Conduct, Part VII, par 7 and 8

170 FAIS General Code of Conduct, Part VII, par 8 (4) (b)

		Advisors. If they don't perform as well as medical schemes that does make use of Independent Healthcare Advisors, the criticism towards medical schemes making use of Independent Healthcare Advisors should be viewed with suspicion. It is not the use of Independent Healthcare Advisors that is the problem but the choice of a distribution model that is not compliant with International best practice.
116	232. Brokers operate mainly in the open medical schemes market. Most restricted schemes do not contract directly with brokers, since employees join medical schemes as a condition of their employment. As explained in the section titled "Market Definition" there are a handful of restricted medical schemes that do compete with open medical schemes for members and these medical schemes may also use broker services. In 2016, nine of the 60 restricted medical schemes reported some payments towards broker and distribution fees.	We agree with this observation of the HMI.
116	There were 2 251 broker organisations and 8 552 individual brokers as if 31 March 2017. Some of the larger brokerages selling medical scheme products include Alexander Forbes Health Pty (Ltd) (Alexander Forbes), PSG Konsult (Ltd), NMG Group (NMG) and AON South Africa (Pty) Ltd (AON). Data submitted to the inquiry indicates that Alexander Forbes, AON, PSG and NMG collectively had just under 12% of the open medical scheme market in 2014. Given this, the inquiry does not view the broker market as concentrated.	We agree with this observation of the HMI that the intermediary market is not contracted.
117	234. Brokers vary based on who they service. Some brokers focus specifically on individual members. Corporate brokers advise large employer groups as well as their employees. Some brokers advise both employer groups and individuals.	We agree with this observation of the HMI.
117	235. In addition to who they service, there are three types of brokers: independent, tied and multi-tied. Independent brokers provide advice on a range of medical schemes. Tied brokers sell only one medical scheme product. Administrators or their subsidiaries often employ tied brokers directly.	We agree with the HMI's three categories of Brokers. However, regarding the employer of tied Agents, it is important to note that Medical Schemes that is self-administered can also employ their own internal marketing agents. Where administrators appoint tied brokers The legislature's intention when creating the FSCA was to regulate, professionalise and accredit financial advisors. This can only be achieved through strong, healthy, and above all, free and fair competition. Consumers have little aptitude, time or ability to read and understand policies and the benefits on offer, much less the fine print in the terms and conditions of each policy and therefore

		rely heavily on professional and accredited advisors to guide them through this process. The promotion of tied agents and the perverse incentives is problematic. The very concept of tied agents, together with financial assistance from their large parent administration businesses, create unfair competition for the independent advisor whom are solely reliant on regulated commission and fees. Tied agents earn more than double the average commission value of independent advisors based on production targets and, therefore, consumers are ill-advised and misled to purchasing unsuitable products. Because of inflated financial aid and resources provided by the parent administration company, tied agents are able to flood the market with product without the requisite advice. This conduct benefits large administrators who then dominate the sector based on market share rather than the quality of their product. The additional fees paid to tied agents are masked as marketing costs by large administrators, which need to be interrogated very closely by the regulator. The role of the Independent Healthcare Advisor is to navigate this quagmire and measure the needs of the consumer and recommend the best suited product from a variety of competing product providers. This stimulates the competition between providers to the benefit of the consumer. Any legislative change that adversely affects the independent advisor and/or its ability to serve individuals, employers, and employees, free of any favour will result in a severe impact to competition and consumers being protected. We also recommend that any aspect regarding the different types of Independent Healthcare Advisors and their remuneration and market conduct be aligned to the views of National Treasury in the Retail Distribution Review (RDR) process, with specific reference to Equivalence of Reward and Intermediary categorization.
117	236. Tied brokers have a vertical relationship with administrators and medical schemes. Because tied brokers deal exclusively with one medical scheme product, they may bring efficiencies as they may better advise the consumer on that scheme's benefit options. They may also have better access to the medical scheme so may be able to deal with	We cannot agree with the observation of the HMI that tied agents can better advise the consumer. Our view is that the Independent Financial Advisor is best position to serve the interest of the consumer better. Please also see our detailed comment on par 235 of the HMI report, page 117.

	consumer queries more effectively than independent brokers. However, due to their close vertical relationship, they will only advise their clients on products in the corporate group and not of other, potentially better, products.	
117	237. Multi-tied agents focus on selling a limited number of medical scheme products. These brokers may bring efficiencies to their clients by providing a deeper understanding of their products than brokers trying to sell a wide range of products. However, as with tied brokers, they will only advise members on the products in their stable, which may exclude a medical scheme that is more appropriate to a particular client.	Please see our detailed comment on par 235 of the HMI report, page 117.
117	Open medical schemes in South Africa often rely on all three types of brokers. Some medical schemes, through their administrators or corporate group, employ tied brokers or have brokerages as subsidiaries within the broader group of companies. The inquiry investigated the relationships between the three largest open medical schemes —DHMS, Bonitas and Momentum Health — and found the following:	Please also see our detailed comment on par 235 of the HMI report, page 117.
117	239. Discovery Ltd has a large tied sales force which markets and sells DHMS products. Discovery's tied agency force (a similar term for tied brokerages) consists of various channels whereby Discovery Life either employs or contracts individuals. The Discovery Connect Distribution Services call centre employs approximately 70 agents (brokers) to advise prospective members on DHMS policies and Vitality policies. There are also approximately 1 000 tied agents who provide financial and product advice to existing and prospective clients on all Discovery products.127 Brokers selling healthcare products earn only the legislated brokerage fees. According to Discovery Health, the proportion of members joining through tied agents fluctuates year to year and was 8% in 2017.	Please also see our detailed comment on par 235 of the HMI report, page 117.
117	240. Given that a majority of DHMS's membership base consists of employer groups, corporate brokers servicing these groups are the largest source of new business for DHMS. These corporate brokers contributed over 50% of total new business between 2012 and 2014. Smaller independent brokers account for 46% of DHMS's new business	Please also see our detailed comment on par 235 of the HMI report, page 117.
117	241. The size of DHMS's tied brokers is substantial, but it does not appear that they bring in significant new business if they only account for 8% of new members.	Please also see our detailed comment on par 235 of the HMI report, page 117.

118	242. Afrocentric Distribution Services (ADS), a subsidiary in the Afrocentric Group, has 22 consultants that provide advice, marketing information and training to independent brokers that sell Bonitas products. Bonitas pays ADS a fee per member per month for this service. Even though ADS is a private company, its contribution is not directly to Afrocentric's overall profits, but is indirect through increasing the administrator's revenue from the administration fees from Bonitas members.	Please also see our detailed comment on par 235 of the HMI report, page 117.
118	243. ADS has shares in Tendahealth (Pty) Ltd. Tendahealth is a tied brokerage for Bonitas that has its own FSB licence. Tendahealth signs up approximately 270 members to Bonitas per month131. Within Tendahealth, a few brokers sell other short-term products from a range of insurers.	Please also see our detailed comment on par 235 of the HMI report, page 117.
118	244. Alternatively, consumers interacting on the website may select to join the medical scheme directly, in which case they complete the required steps and Bonitas retains the broker fee component. Approximately 15% of Bonitas' members join the medical scheme directly. ADS believes that young individuals are increasingly opting to search for information on-line and join directly. Approximately 70% of Bonitas members are part of an employer group	We have no contribution to make other than to state that these practices complies with the current legislative framework.
118	245. Momentum Health, the third largest open medical scheme, also uses tied brokers. Within the MMI group, Momentum Financial Planning and Momentum Healthcare Distribution sell Momentum Health products as well as other MMI products to individuals and employee groups. Momentum Financial Planning consists of independent brokers, franchisees and employees of the MMI group. There are 700 brokers in Momentum Financial Planning, of which 230 have accreditation to sell medical scheme products. Another tied force within the MMI group is Momentum Healthcare Distribution which focuses on different market segments to that of the Momentum Financial Planning brokers.	Please also see our detailed comment on par 235 of the HMI report, page 117.
118	246. Approximately 46% of all members joining Momentum Health in 2017 joined through tied brokers, 49% joined via independent brokers and 5% joined Momentum Health Medical Scheme directly.	Please also see our detailed comment on par 235 of the HMI report, page 117.
118	247. Medical schemes pay brokers a stipulated commission on behalf of the members that the brokers have signed up to a particular scheme. For a medical scheme to	In so far as the medical scheme merely act as a conduit for payment of commissions we agree with this observation of the HMI. We have dealt with

	pay commission to a broker, the broker must have a contract with that medical scheme. The medical scheme will remunerate the broker the lower amount of either 3% plus value added tax (VAT) of the member's contribution amount, or R90 plus VAT per main member (family) per month. The aim of standardising commission across medical schemes is to remove adverse incentives since brokers earn the same commission structure regardless of which medical scheme they direct members to.	these types of issues in our main document. Please see the sections that deal with **myth 1, 2 and 3**.
118	248. The current MSA regulations provide consumers with the right to appoint any broker. No contribution or premium discounts apply if a consumer goes directly to the product supplier. Broker payments count towards the medical scheme's nonhealthcare expenditure. Where a member joins a medical scheme directly and not through a broker, the medical scheme retains the amount that they would have paid had the member used a broker. Therefore, the more members that join the medical scheme directly, the lower the broker fees' contribution to the medical scheme's overall non-healthcare expenses. Broker fees, inclusive of distribution fees, was approximately 14,1% of total non-healthcare expenses for open medical schemes for 2016	We agree with the HMI's observation that consumers have the right to appoint a broker. We also need to point out that consumers have the right to terminate the services of a broker and the medical scheme must adhere to the consumers instruction[171]. When a member chooses to transact directly with the Medical Scheme the medical scheme fulfils some of the functions of the Independent Healthcare Advisor, which is not free. The HMI have heard evidence that these services are expensive. The no discount makes sense.
119	249 While medical scheme brokers' commission is standardised, they may supplement their income by earning the regulated commission from the sale of a variety of other insurance non-financial products provided they have all the necessary licences. In addition, as mentioned above, brokers may earn income for consulting services they provide to employer groups or medical schemes. This advice could include actuarial services on the types of benefit options the restricted medical scheme should offer, and around financial input required to keep the medical scheme stable. This advice could also contribute towards amalgamations between restricted medical schemes and open medical schemes	We agree with the HMI's observation.
119	250. The Competition Tribunal's view is that legislation governing broker remuneration supports the pro-competitive role of brokers. The Tribunal found that consumers are encouraged to use brokers as they do not pay brokers directly. The legislation prohibits insurers from paying brokers an incentive	We agree with the second part of the HMI's observation. However, we disagree with the HMI's observation regarding who pays the broker. We deny that it is not the member. The mere fact that the commission is part of the product does not mean it is not the member that pays the broker. The strongest evidence for this argument lies in the fact that if the member instructs the medical scheme to

171 Regulation 28 (7) of the Regulations promulgated in terms of the Medical Schemes Act

	bonus, which prevents brokers form developing 'comfortable' relationships with insurers and protects the broker's client base	stop paying the broker then the medical scheme must comply with the instruction. The member is in full control of the payment to the broker.[172]
119	251. While brokers should regard consumers as their main clients/principals, the current remuneration structure, in which the medical scheme contracts with and pays the broker, blurs this relationship. Some stakeholders stated that consumers do not know that their monthly contribution includes a broker fee, whether they use a broker or not. In some instances, consumers incorrectly believe that broker services are free.	We disagree that the current remuneration structure blurs the obligation the Independent Healthcare Advisors have towards their clients. The relationship is not established by the remuneration structure but by the FAIS ACT[173].
119	252. Some stakeholders are concerned that medical schemes think of the 3% member's contribution as their own contribution to the broker, rather than that of the members'. Thus, they believe that large medical schemes could influence broker behaviour since a broker could lose revenue if a medical scheme decided to cancel its contract with a broker. Consequently, brokers may have difficulty advising members to leave a scheme that does not suit their needs, if that scheme makes up a large proportion of the brokerage's income. Not all brokers share this view. Some brokers and administrators are of the view that the corporate broker environment is very competitive and brokers risk losing employer groups as clients if they do not act in the client's best interest. FAIS tries to address this by insisting that the broker always act in consumers' interest.	We believe that if stakeholders believe that the 3% commission is their payment to Independent Healthcare Advisors then they are factually mistaken. As we have stated before the strongest argument against this mistaken view is that members can instruct a medical scheme to immediately terminate commission Independent Healthcare Advisors and the medical scheme must comply with the instruction[174]. We strongly agree with the HMI's observation that the FAIS Act require the Independent Healthcare Advisors to act in the best interest of their clients.
119	253. Stakeholders stated that the current remuneration structure incentivises brokers to favour high cost medical schemes and more expensive benefit options to maximise their commission. Other stakeholders did not support this view as they explained that the range in commission is too small to influence their advice. They prefer to build a long-term relationship with their clients. Providing poor advice to employers in an employer group to gain a relatively small percentage increase in revenue is even riskier as they could lose significant revenue from losing the contract with the entire group. They argued that businesses operate in a competitive corporate environment and corporates contracting brokers evaluate all the services they receive.	If the FAIS Act obligates Independent Healthcare Advisors to act in the best interest of their client's commission cannot ever be a driver. However, we agree that the argument of some stakeholders that Independent Healthcare Advisors would want to place members on higher options to maximise commission is unfounded and due to the commission cap highly improbable.

172 Regulation 28 (7) of the Regulations promulgated in terms of the Medical Schemes Act

173 FAIS General Code of Conduct

174 Regulation 28 (7) of the Regulations promulgated in terms of the Medical Schemes Act

	Switching costs are low, so if they do not think the service they receive from the broker adds value, they will start the tender process for a new brokerage.	
120	254. The CMS was concerned that brokers encourage members to 'buy-down'. Brokers market health insurance products to healthier members of medical schemes, who are encouraged to buy down to cheaper plan options and cover the differences in benefits by purchasing gap cover products at cheaper rates.	We respectfully disagree with the CMS's submission in this regard. The buy down trend is primarily due to affordability constraints members experience and no prove exist that it is broker induced. Further, when a consumer buys down they also lose quite a lot of other benefits. One example is that the amount allocated to savings accounts may be substantially less. The formularies and protocols for lower options are usually also more restrictive than higher options. This is not covered by GAP products. However, the comment of the CMS may be symptomatic of the fact that the CMS is tasked with only understanding and regulating medical schemes, whereas the Independent Healthcare Advisors look after the full financial portfolio of the member. This regulatory misunderstanding is perhaps the primary reason why the conduct of Independent Healthcare Advisors should be regulated by the FSCA who understands the relationship between a range of financial products and the responsibility to provide appropriate advice. This level of understanding falls outside the scope of the CMS and their misunderstanding is to be expected.
120	255. The Board of Healthcare Funders of Southern Africa (BHF) and ADS argue that the current remuneration regulation is inadequate. The current accounting measures do not track the flow of finances between medical schemes, brokers and administrators. Medical schemes do not report broker remuneration independently or uniformly. Rather they combine broker remuneration other non-healthcare expenditure including marketing and distribution costs which are not restricted and regulated to the same extent as broker remuneration. The lack of uniform reporting makes comparison across medical schemes challenging.	We agree with the BHF and ADS that commission should be split from all other distribution and marketing expenses. We also agree that reporting should be standardised. This can easily be achieved by the CMS issuing a reporting guideline as is the practice.
120	256. Approximately 97% of DHMS, 75% of Bonitas, and 95% of Momentum Health Medical Scheme members joined their respective scheme via brokers. These figures are in contrast to what the inquiry gathered from its customer survey, which revealed that only 25% of respondents who have medical aid selected a medical scheme via a broker. 63% of respondents said they did not have a broker,	We are not able to agree with or deny the facts submitted by DHMS, Bonitas and Momentum. However, we agree that Independent Healthcare Advisors services are common and in high demand. Therefore, we are not surprised by the high utilisation of Independent Healthcare Advisors

	while 12% were unsure. This could partly be due to employees joining through their employer, and these employees not being aware that their membership falls under the auspices of their employer's broker.	
120	257. With regard to the role of individual brokers, the inquiry found that individuals are not always aware of the role that brokers can and should play. Consumers may consult with brokers to select a medical scheme, but many do not know that the broker can assist them with claims and other engagements with the medical scheme. In the consumer survey, 56% of respondents who said they used brokers rarely communicated with them, and 16% had not communicated with their brokers at all during the last 12 months .	We cannot comment on the research conducted by the HMI. Research outcomes are also biased towards the sample and the type of questions. Qualitative and quantitative research also yield different results. Triangulation techniques also assist in providing a more accurate research outcome. We are not sure of how the research was conducted. However, we cannot agree to a low awareness of the role of the broker. Please see where this is addressed in detail in our main document of our submission in the sections titled: "**Role of the Independent Healthcare Advisor" a**nd **"The Undisputed value of the Independent Healthcare Advisor"**
120	258. The inquiry agrees with stakeholders that the practice of reporting broker fees inclusive of distribution fees does not allow meaningful comparisons between medical schemes. Nonetheless, the inquiry looked at CMS reported broker fees for open medical schemes (inclusive of marketing, advertising and distribution fees), and found that Fedhealth spent the most at R113.70 per average member per month (pampm) in 2016 (for growth in beneficiaries of 2.4% from 2015) followed by Momentum Health at R103.70 pampm (for growth of 7.3% from 2015) and Bonitas at R103.30 pampm (for growth of 15.1% from 2015). DHMS spent significantly less at R90.60 pampm (for a growth of 1.6% from 2015). Because of DHMS's size, its marketing fees are spread over significantly more members. The inquiry expects there to be economies of scale for large medical schemes as the marketing fees could be spread over significantly more members.	We agree that commission should be split from all other distribution and marketing expenses. We also agree that reporting should be standardised. This can easily be achieved by the CMS issuing a reporting guideline as is the practice.
121	259. On the other end of the spectrum, Cape Medical Plan does not incur any broker, marketing and distribution fees. Medimed Medical Scheme and Genesis Medical Scheme have minimal broker spend at R0.1 and R25.1 pampm respectively. Even with these low amounts, Medimed Medical Scheme grew by 4.2% over the year and Genesis Medical Scheme by 2.3%. Cape Medical Plan's number of beneficiaries decreased by 5.3% from 2015. It is unlikely that this decrease is solely to Cape Medical Plan's approach to brokers. However,	Marketing and distribution are a key component of the success of any financial product. Although, we must respect the choice of medical schemes not to make use of brokers or to market their products, it will be challenging to then grow that medical scheme. The observation of the HMI is noted.

	the inquiry is of the view that one factor contributing to this decline is Cape Medical Plan's decision to not use brokers, or spend any money on marketing.	
121	260. The inquiry looked at the regulated broker remuneration from medical scheme products. The broker fees were capped at R80 in 2016 which means that anyone that paid about R2 665 in premiums would have paid the maximum cap. The CMS annual report figures for 2016 show that there are several benefit options with monthly contributions that were less than R2 665. Brokers could therefore have an incentive to advise members to take more comprehensive cover than necessary to increase their commission. However, the inquiry is of the view that many consumers are limited to the amount of cover they can afford. This, rather than the broker, dictates the benefit option range from which the member can select. The inquiry also agrees with stakeholders' comments that brokers are unlikely to sacrifice a long-term source of income for marginally higher income in the short-term.	We agree with the HMI's conclusion in this regard. However, we would like to just emphasise that the maximum cap in commission is applied on the family contribution and not an individual members contribution.
121	261. The inquiry did not find any specific evidence of brokers advising members to buy down to cheaper medical scheme products and then take gap cover for the additional cover. In certain circumstances, this type of advice may be rational for particular individuals. The implications of this on the broader medical scheme market is a result of the current regulatory environment governing medical schemes and health insurers and is not necessarily due to sinister behaviour by brokers. This is discussed in more detail in the section above on demarcation.	We agree with the HMI's submission in this regard. The buy down trend is primarily due to affordability constraints members experience and no prove exist that it is broker induced. Further, when a consumer buys down they also lose quite a lot of other benefits. One example is that the amount allocated to savings accounts may be substantially less. The formularies and protocols for lower options are usually also more restrictive than higher options. This is not covered by GAP products. However, the comment of the CMS may be symptomatic of the fact that the CMS is tasked with only understanding and regulating medical schemes, whereas the Independent Healthcare Advisors look after the full financial portfolio of the member. This regulatory misunderstanding is perhaps the primary reason why the conduct of Independent Healthcare Advisors should be regulated by the FSCA who understands the relationship between a range of financial products and the responsibility to provide appropriate advice. This level of understanding falls outside the scope of the CMS and their misunderstanding is to be expected.
121	262. Administrators are particularly interested in the growth of the medical schemes under their administration because they receive a per member per month fee. It is therefore in the	We have dealt with these types of issues in our main document. Please see the sections that deal with **myth 3**.

	administrator's interest to incentivise brokers to channel consumers to the medical schemes they administer. As discussed in the chapter titled "Industry Overview" the large administrators are subsidiaries of large corporations that sell a variety of financial and non-financial products.	
121	263. Brokers may sell more than one type of financial product as long as they have the relevant licenses for each product from the FSB (and CMS in the case of medical scheme products). The payment of cobranded products (such as wellness and loyalty programmes, and health insurance products) have different commission structures which fall outside of the MSA and therefore the CMS's oversight	We agree with the HMI's observation.
121	264. The HMI heard that medical schemes and administrators circumvent the regulation whereby brokers sell additional products or provide additional remuneration to brokers by paying for marketing activities or surveys. Profmed states that: "Innovative reimbursement schemes for brokers have been developed. Schemes and administrators often resort to other mechanisms to enhance brokers' remuneration. These mechanisms might entail the selling of additional products, such as gap cover, insurance and loyalty programs…. (T)he interests of consumers are often secondary to those of brokers when products are sold"(profmed)	We disagree that the submission of Profmed is entirely correct. No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
122	265. In his submission, Brian Watson says: "Marketing fees are a ploy used by some administration companies and medical schemes to remunerate brokers beyond the limits prescribed by law. Typically, brokers are tasked with collecting information about the market (whatever they mean) and they are paid fees by the administrator or medical scheme. As this service is not 'broker services' as defined in the MSA, the commission cap of 3% is effectively avoided and the broker receives more money than he is legally entitled to."	We disagree that the submission of Brian Watson is entirely correct. No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
122	266. Bestmed states: "Creative products have been developed in respect of loyalty programmes, training services etc to ensure membership growth through broker services but the remuneration does not fall under S65 since the products fall outside the regulatory net of Medical the Medical Schemes Act."	We disagree that the submission of Bestmed is entirely correct. No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS.

		We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
122	267. In its submission to the HMI, Medscheme says: "In private healthcare, brokers earn commission limited to 3% of gross contribution, subject to a maximum Rand value currently set at R71.07 plus VAT. This level is much lower than other insurance products in the South African market, which is typically nearer 20% of premium."	We agree with this portion of Medscheme's submission.
122	268. Medical schemes and administrators also told the inquiry that incentives from medical schemes to brokers originate from the sale of a bundle of other products from inside the administrator's corporate structure and outside of the medical scheme environment. Brokers who sell medical scheme products together with insurance products have an advantage over those selling medical scheme products only as they earn higher commission from one individual and qualify for rewards from the group of companies. Smaller medical schemes and administrators that are not linked to large corporates and do not have a basket of products to sell could be at a disadvantage as brokers would prefer to sell a basket of products.	We disagree with these submissions to the MHI. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
122	269. Brokers told the inquiry that the commission from the sale of medical scheme products is only sufficient on its own if they have a very large client base. This is particularly the case for brokers servicing individuals as they must do a significant amount of work to capture each individual client. Smaller, independent broker businesses are sustainable when they offer other services beyond medical scheme products only, which may come from a number of different companies. One brokerage started as purely health care consultants but has diversified into wellness and retirement consulting over the last five years.	We agree to this observation of the HMI and these submissions to the HMI.
122	270. In relation to these allegations, both brokers and Discovery Health emphasise that regulation prevents financial institutions from offering any additional incentives regardless of whether the broker sells other products such as short-term insurance or life insurance from a financial institution.160 Discovery Health, in response to the Revised Statement of Issues, said that brokers may sell other Discovery products such as Discovery Life, Discovery Vitality or Discovery Invest products but that no	We agree with the submission of Discovery Health in this regard. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.

	entities in the Discovery Group can pay a combined preferential commission to encourage a broker to sell more of the group's products. Each product is subject to its own maximum commission. Discovery Health disagreed with the allegation that Discovery Ltd launched Vitality as a way to pay higher commission to brokers. Rather, brokers receive commission in line with the work involved in selling the products. Discovery Health emphasises that Vitality exists to encourage members to improve their own health by living a healthier lifestyle.	
123	271. ADS says that the Afrocentric group does not have other financial products such as life insurance in the group that they can combine with medical scheme products. Its subsidiary, Tendahealth, the telemarketing tied agents, sell only Bonitas products and earn the regulated commission. However, some brokers in Tendahealth sell other insurance products from a variety of companies outside of the Afrocentric group.	We cannot agree or disagree with the submission of ADS or Tendahealth. However, these practices are legal and acceptable.
123	272. The inquiry found that the regulators have an important role in monitoring broker behaviour and incentives. The FSB and the CMS can remove brokers' licences and accreditation. The FSB can also impose financial penalties if brokers are in contravention of FAIS. FAIS defines allowable income for brokers to prevent remuneration over and above the regulated commissions. Neither the CMS nor FSB collect data on the total remuneration brokers receive. As already explained, the broker fees reported in the CMS annual report include marketing and distribution costs. This consolidated reporting makes it difficult for the CMS to monitor medical scheme expenditure on brokers alone to verify that the payments were within the	We agree that commission should be split from all other distribution and marketing expenses. We also agree that reporting should be standardised. This can easily be achieved by the CMS issuing a reporting guideline as is the practice.
123	273. Several brokers sell a range of products from a particular group. In order to assess whether the ability to sell a basket of financial conglomerate products interfered with brokers ability to provide independent advice, we considered the revenue that they received from other products. The data provided to the inquiry by the large healthcare brokers showed that much of their income stems from medical scheme commission with less than 10% coming from other insurance products and less than 3% of their total revenue from wellness/ loyalty programmes.	We are not able to agree on the exact income splits but agree that many Independent Healthcare Advisors sell other financial service products than only medial scheme products.

123	274. Brokers are likely to advise clients to take a combination of products from one corporation rather than medical scheme and wellness products from one provider and life insurance from another, for example. To some extent, this is so that members can maximise their rewards from the loyalty/wellness programs. In addition to this, the inquiry found that in some instances, brokers earned recognition through remuneration linked to the company's share price and other incentives such as gaining access to conferences and events. This recognition is distributed to tied brokers based on complex formulas including components of medical scheme products sold combined with other products in the group. Other companies in the group pay for these forms of recognition, so payment does not come from the medical scheme directly, or indirectly from the administrator. However, the combined total of sales, including health products count, will be sufficient to incentivise brokers to sell that group's products rather than combining a medical scheme product with another company's life product. This is one way that medical schemes and administrators circumvent broker payments as it places the emphasis on the group of products at the expense of individual medical scheme products. It also places the medical schemes that are not part of a corporate group at a disadvantage as they are unable to benefit from similar arrangements.	We cannot agree to this. This is a generalisation that does not comply with the requirements as stipulated by the FAIS General Code of Conduct. We have also dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
123	275. The inquiry also found that brokerages can and do receive additional income from consulting services which are not necessarily included in marketing and distribution costs. In the one instance, this additional revenue was up to 30% of the brokerage's total income. Brokers earn income from advising employers/ corporates, particularly where employers have their own restricted medical scheme.	We agree with the observation of the HMI but cannot comment on the exact detail.
124	276. There are historical examples where medical schemes have circumvented the regulated payments. In 2008, allegations surfaced that Medshield paid brokers between R400 and R850 per member for new members under the age of 42 years who completed a questionnaire. The Registrar deemed these payments for research fees to the value of R28 million unlawful and wasteful expenditure and in contravention of Section 65(2) of the MSA.	No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**.
124	277. The inquiry found that the brokers had significant exposure to DHMS. Submissions	We agree with this observation. However, the exposure to one provider must also be disclosed to

	from brokerages revealed that their revenue from DHMS ranged from about 50% to over 70% of their total revenue. Brokers' exposure to Discovery as a group is even more significant if other Discovery products are included. The inquiry noted that the large percentage of revenue from one medical scheme reflects the large market share of that scheme. However, it is likely that where a broker receives a large portion of income from one medical scheme, that broker would want to maintain good relationships with that medical scheme.	members in terms of the FAIS General Code of Conduct. This provides members with the correct market behaviour protection.
124	278. Administrators are able to influence the brokers' advice through the extent of training and quality of service they provide. DHMS and Discovery Health spend significantly more time engaging with brokers, and this improved the brokers' understanding of their product and encouraged them to sell it.	We disagree that Independent Healthcare Advisors behaviour can be influenced in such a way that the Independent Healthcare Advisor is incentivised to thwart the FAIS Act and act in a way that is not in the best interest of the member. Should this happen the Independent Healthcare Advisor is liable for any harm suffered and can even lose their licence. The regulatory muster should be enough to prevent Independent Healthcare Advisors from acting contrary to their client's best interest.
124	279. Corporate brokers told the inquiry that, in recent years, employers are increasingly allowing for split risk, meaning that they allow their employees to select between two or more medical schemes. Brokers play a critical role in recommending the alternative or competing medical scheme. Brokers explained that they recommend additional schemes that offer a greater range of options when combined with the incumbent. Bonitas and DHMS, for example, have different product offerings and, when combined, provide a wide selection between traditional plans and savings accounts. DHMS and Momentum Health's products, on the other hand, are very similar in nature. Bonitas has traditional benefit options, whereas Momentum Health and DHMS both offer a range of new generation plans, with savings accounts.	We agree with this observation of the HMI.

124	280. Splitting risk increases competition for the incumbent medical scheme as employees can select between the medical schemes. Brokers told the inquiry that incumbent medical schemes are apprehensive about splitting risk and will try to discourage it. To do so, the medical scheme, which may initially not underwrite new employees to the firm, may threaten to institute underwriting if the employer allows a new medical scheme to enter. Brokers told the inquiry that the extent to which the medical scheme implements underwriting depends on which medical scheme is selected and whether the new scheme provides similar products.	We agree with this observation of the HMI.
124	281. In response, Discovery Health says that DHMS does not apply different underwriting policies based on whether one or another scheme is offered as an alternative: "When an employer group has historically had all of its employees with DHMS decides to offer choice of one or more alternative schemes, DHMS makes every effort to accommodate this choice and to maintain the applicable underwriting concessions. In a limited number of cases where the risk is determined to be very high, the underwriting status is changed and underwriting concession is withdrawn" When probed further on this, Discovery Health explained that it only withdrew the underwriting concession in one instance, where the risk pool was going to be substantially worse following the splitting of risk.	Underwriting decisions is the preserve of every medical scheme. We will not express an opinion on this practice.
125	282 ADS told the HMI that the incumbent medical scheme may implement underwriting if they are of the view that the new entrant will attract all the good risk and leave the incumbent with the bad risk. Medical schemes also consider whether to implement underwriting or not when employers wish to add them to the selection for employees. There is a concern that, depending on the incumbent scheme, the new medical scheme may only attract the bad risk (ie the sick and the elderly). Medical schemes may agree to be added to the employee selection, but they will want to underwrite future employees to mitigate against this.	Underwriting decisions is the preserve of every medical scheme. We will not express an opinion on this practice.
125	283. MMI Health explained that brokers have told them anecdotally that incumbent medical schemes may threaten to implement underwriting if the employer selects Momentum Health as the new medical scheme. Momentum Health does not apply	Underwriting decisions is the preserve of every medical scheme. We will not express an opinion on this practice.

	underwriting to a new employee if the employee chooses to join Momentum Health at appointment stage. However, if the employee decides, after some time, to switch (possibly because of anti-selective reasons, then the medical scheme will impose underwriting.	
125	284. The inquiry is of the view that brokers play an important role in advising employer groups given the number of employees that join medical schemes through their employers. Employers allowing employees a choice of more than one medical scheme is good for competition and benefits the employee. The inquiry heard conflicting stories relating to whether or not medical schemes implement or threaten to implement underwriting when an employer group splits risk, and therefore cannot make a finding on whether and the extent to which it occurs. There may be legitimate reasons for incumbent medical schemes to implement underwriting where the employer introduces an alternative medical scheme. This is particularly where the entrant attracts all the good risk harming the overall stability of the incumbent medical scheme's risk pool. However, if large open medical schemes threaten to implement underwriting, even if they do not follow through with their threat, this behaviour constitutes a strategic barrier to entry that protects their position in the open medical scheme environment.	We agree with the HMI's observation that Independent Healthcare Advisors play an important role of advising employers and their employees. In this regard we also dealt with this in the section that deals with the **"Role of the Independent Healthcare Advisor"** Underwriting decisions is the preserve of every medical scheme. We will not express an opinion on this practice.
125	285. In some instances, members join medical schemes without the assistance of a broker. The inquiry heard speculation that when members join directly, medical schemes assign brokers to these members without their knowledge. Because there is no discount for members joining a medical scheme directly, the member would not know if the medical scheme allocated a broker to them unless they asked the medical scheme. It is alleged that the assignment of these orphan members is one way that medical schemes can influence broker behaviour by increasing their commission.	We agree with the observation of the HMI that possibilities exist for medical schemes to use orphan brokers to gain goodwill of supporting brokers. However, two aspects are important. Firstly, any such action should be a contravention of the Medical Schemes Act and would be an offence in terms of the Medical Schemes Act. We trust that the regulatory muster of the CMS is enough to prevent these undesirable contraventions of the Medical Schemes Act. Secondly, the HMI on page 120 paragraph 256 stated that approximately 97% of DHMS, 75% of Bonitas, and 95% of Momentum Health Medical Scheme members joined their respective scheme via brokers. The probability for this to be effective or to happen on a large scale seems improbable.
125	286. The brokers interviewed were aware that medical schemes used to allocate members to brokers, but doubted that the practice continued. The CMS expressed a similar view. This practice would go against FAIS as FAIS requires that each person must undergo a needs assessment, which would not take place	We agree with this observation. Also, please see our comment regarding paragraph 285 on page 125.

	if medical schemes merely assigned members to brokers.	
125	287. If the CMS suspects a medical scheme of doing this, they will follow up with the broker and medical scheme and will require information such as the broker appointment letter, broker book, etc. Brokers confirmed that the CMS can audit the medical scheme and broker and request to see the appointment letter before the medical scheme can pay commission.	We agree with this observation. Also, please see our comment regarding paragraph 285 on page 125.
126	288. The HMI is of the view that allocation of orphan members is more likely to be a concern where individual members join a medical scheme directly rather than through an employer group (who will also most likely have gone through a broker). No evidence has been received to suggest that the practise of allocating orphan members continues, after FAIS stopped it.	We agree with this observation. Also, please see our comment regarding paragraph 285 on page 125.
126	289. There is a clear need for brokers to provide independent and valuable advice to members, and that members know what services brokers can provide to them. In many cases, members are unaware that they pay a broker indirectly through their monthly medical scheme contribution, and that they do not pay lower fees by not going through a broker. They also do not know all the ongoing services the broker may provide.	We agree that there is a need for the Independent Healthcare Advisor.
126	290. This lack of transparency and complexity means that there are many different ways in which brokers' incentives may be skewed. Their advice may favour medical schemes and administrators over the members.	We agree with the HMI's observation that Independent Healthcare Advisors play an important role of advising employers and their employees. In this regard we also dealt with this in the section that deals with the **"Role of the Independent Healthcare Advisor"**
126	291. The current environment lacks transparency surrounding broker remuneration and may influence broker incentives. There is a need for greater transparency for the consumer on all the rewards, both financial and other that brokers receive from selling a combination of products. Furthermore, there is a need for greater oversight from both the CMS and FSB on the reporting and monitoring on broker remuneration from all the products they sell.	We respectfully disagree with the HMI's observation in this regard. Firstly, the extension of the HMI's finding on products sold by Independent Healthcare Intermediaries, other than medical schemes were not part of the scope of the HMI. It is our respectful submission that the HMI extended their observation too far. We respectfully disagree that the current environment lacs transparency relating broker remuneration. Independent Healthcare Intermediaries are compelled by the FAIS General Code of Conduct to disclose their remuneration.[175] What is lacking is that the CMS enforce correct disclosure and reporting of broker commission excluding marketing and distribution fees.

175 FAIS General code of Conduct, Part VI, Section 7 (1) (c) (vi)

126	292. It is difficult, even for brokers, to know and understand all the scheme and benefit options. Brokers are thus more likely to favour products from medical schemes which invest in educating brokers on their products.	We not able to agree or disagree with this observation of the HMI. However, it is less important who the Independent healthcare Intermediary favour and for what reason. The FAIS Act and the FAIS General Code of Conduct place an obligation on the Independent healthcare Intermediary to serve the interests of their clients.
126	293. The inquiry found that the dominant open medical scheme, DHMS, is important to brokers as a large part of their income is dependent on a contract with this scheme.	observation of the HMI. However, it is less important who the Independent healthcare Intermediary favour and for what reason. The FAIS Act and the FAIS General Code of Conduct place an obligation on the Independent healthcare Intermediary to serve the interests of their clients.
131	331. The CMS stated that the main difference in the services administrators provide to open and restricted schemes is likely to be in relation to schemes benefit designs and whether the scheme contracts with brokers or not.	We respectfully disagree with the CMS submission in this regard in so far as this is a oversimplification of the difference between open and restricted membership medical schemes.
137	352. Another barrier to entry is that large administrators can capture their medical schemes members by cross-selling other insurance products, often through their relationships with brokers. Medical schemes that do not belong to large conglomerates battle to attract broker clients to the medical schemes under their administration. Linked to this, members with a bundle of products from one group perceive the switching costs for their medical scheme products to be high. Medical schemes and administrators stated that administrators use wellness programmes to attract and retain members on a particular scheme.	No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with myth 3.
139	365. The HMI agrees with stakeholders' assertions that large administrators benefit from their relationships with both tied and independent brokers. In addition, large administrators (for instance Discovery Health and MMI Health) also benefit from belonging to corporations that also have wellness programmes in the group of companies. These administrators use wellness programmes strategically as a way to attract medical schemes as well as members to the schemes they administer. In some cases the administrators, as well as other financial services companies in the group, pay money to the wellness programs, subsidise these programmes. They may allow medical schemes and administrators to attract young and healthy members and prevent members from switching to other open medical schemes.	No medical scheme is permitted to pay more than the legislated commission. Any such contravention is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with **myth 3**
139	370. Administrators and other companies in the group pay additional funds (either as fees	No medical scheme is permitted to pay more than the legislated commission. Any such contravention

	or in the form of intercompany transfers) to loyalty and wellness programmes. The lack of transparency surrounding the funding of these programmes may allow medical schemes and their administrators to circumvent regulations through increasing the commission brokers receive. This may provide them with an unfair competitive advantage in the market.	is an offence in terms of the Medical Schemes Act. Many of the other "marketing" agreements that was contravening the Medical Schemes Act was closed by the CMS. This clearly demonstrate the regulatory muster of the CMS. We have dealt with these types of issues in our main document. Please see the section that deal with myth 3
460	32.3. That schemes encourage member participation in its Annual General Meeting (AGM). This includes: 32.3.1. Modifying the requirements for attendance at the scheme AGMs to ensure adequate representation of members who are not employees, brokers, officers, consultants or contractors of the scheme or its administrator and do not have a material relationship with anyone contracted to or employed by the scheme to provide administrative, marketing, broker or managed care services. In other words, all conflicts of interest must be avoided.	We agree with the HMI's observation that conflicts of interest should be avoided regarding AGM's and Trustee elections.
460	32.7. That the broker system is an active option system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those that do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.	The current use of an Independent Healthcare Intermediary is an active opt-in and opt-out system. Firstly, the only way in which an Independent Healthcare Intermediary can earn commission is by way of an explicit appointment by the member or an employer on behalf of its employees. Furthermore, members can then also at any stage terminate the employment or use of the broker and the medical scheme must immediately stop paying the Independent Healthcare Intermediary[176]. What may be helpful for improved transparency is that medical schemes be compelled to on all correspondence with the member also provide the detail of the appointed broker.
461	54. We believe that brokers play an important role in advising members but that their interests should be aligned more closely to those of applicants/ members. The HMI makes the following recommendations:	We agree but is also humbled by this observation of the HMI. Please see where this is addressed in detail in our main document of our submission in the sections titled: "**Role of the Independent Healthcare Advisor" a**nd **"The Undisputed value of the Independent Healthcare Advisor"**
461	54.1. That the broker system must change to an active opt-in system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those who do, the scheme will facilitate the payment to the	The current use of an Independent Healthcare Intermediary is an active opt-in and opt-out system. Firstly, the only way in which an Independent Healthcare Intermediary can earn commission is by way of an explicit appointment by the member or an employer on behalf of its employees. Furthermore,

176 Regulation 28 (7) of the Regulations promulgated in terms of the Medical Schemes Act

	broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees.	members can then also at any stage terminate the employment or use of the broker and the medical scheme must immediately stop paying the Independent Healthcare Intermediary[177]. What may be helpful for improved transparency is that medical schemes be compelled to on all correspondence with the member also provide the detail of the appointed broker.
462	54.2. Members must be free to choose any licensed broker they wish and not just those with contracts with particular schemes,	Although, we agree with the freedom of choice that the HMI would like to strengthen, we are concerned about the ability of the appointed Independent Healthcare Intermediaries ability to perform the duties bestowed upon it in terms of the FAIS ACT and the FAIS General Code of Conduct where there is no contract with the medical scheme to which the member belongs. Further, this recommendation of the HMI may be challenging as it also infringes on the rights of medical schemes to decide to make use of Independent Healthcare Intermediaries and who those Independent Healthcare Intermediaries should be. Also, about the HMI's comment that a client must be able to appoint a broker/intermediary who is not contracted to that medical scheme flies directly in the face of the latest Board Notice 194 issued by the FSCA relating to the Fit and Proper Regs with specific reference to product accreditation (training). Whilst the broker/intermediary with must be a licensed FSP and have to complete the COB training (classes 1 and 9 for healthcare intermediaries), he will also have to complete the product accreditation training which he will only be able to do as a contracted intermediary.
462	54.3. Brokers who are marketers for a specific scheme (and are thus not independent) should earn lower commissions than independent agents,	We prefer not to express our opinion to this recommendation. We would rather urge the HMI to seek the opinion of National Treasury in this regard as they have embarked on a four-year process to determine different remuneration levels for brokers. This process is known as the Retail Distribution Review.
462	54.4. Medical schemes must report broker fees separately to the CMS from distribution and other marketing fees. The CMS must also make these separate figures available in the annual report	We agree with this recommendation of the HMI.
462	55. As a condition of registration, medical schemes must also be able to deal directly with the public without the use of brokers. This would include administering membership applications.	We agree with the first part of this recommendation of the HMI and would like to draw the HMI's attention to the fact that this is the current status quo.

177 Regulation 28 (7) of the Regulations promulgated in terms of the Medical Schemes Act

		We would like to disagree with the second part of the HMI's recommendation to the extent that Independent Healthcare Intermediaries are in any case precluded from performing duties as an administrator if not accredited as an administrator. Administering membership applications is not a duty of the Independent Healthcare Intermediary.