Office of the Registrar of Medical Schemes

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Remuneration of Health Brokers: Revising the Regulatory Framework

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Introduction

1. Health brokers are regulated in terms of the provisions of the Medical Schemes Act, 1998 (MSA) and the Financial Advisory and Intermediary Services Act (FAIS). While broker conduct is regulated in terms of both these pieces of legislation, remuneration of health brokers is regulated in terms of the MSA (and the regulations made thereunder).

2. Medical schemes spent one billion rands on brokers in 2007. Given the affordability constraints on medical scheme membership, it is incumbent on the Council for Medical Schemes (the Council) to assess the impact of the regulatory framework to ensure that consumers get value for money in return for this expenditure.

3. As importantly, it is important to ensure that the incentives for brokers created by remuneration in terms of the regulatory framework are consistent with consumers receiving best advice and assistance which is not tainted by the possibility of conflict of interest.

4. Based on our experience of implementing the current regulatory framework pertaining to broker remuneration over the past few years, we are of the view that it has a number of shortcomings in this regard.

5. Proposals are therefore being developed for revision of the regulatory framework. Preliminary proposals are articulated in this discussion document. It is important to emphasise that these proposals deal only with revision of the regulatory framework around broker remuneration, and does not directly deal with issues of regulation of broker conduct.

6. Given that this is an issue which directly affects consumers, it is our hope that as broad a spectrum of consumer views can be taken into account in finalization of the

policy and regulatory framework – of course, alongside the views of other affected stakeholders.

7. Please use this opportunity to make submissions on these proposals. Tell us what you think of them, and why. If you find some of the ideas particularly good, please say so. If you find them problematic, let us know this as well. If you have even better suggestions, by all means make them.

8. We would be grateful to receive your submissions by no later than **6 February 2009**. They can be emailed to broker_comments@medicalschemes.com.

Context

9. Consumers[1] wishing to join a medical scheme face a choice between a bewildering number of medical schemes and benefit options. In 2007, there were 41 open schemes[2] and 218 registered benefit options in those schemes.

10. There is little uniformity between these schemes and options in terms of what benefits they offer or how those benefits are structured, and they all come at different prices.

11. It is therefore very difficult for consumers to find out for themselves what is on offer, compare value-for-money, and ascertain which schemes and benefit options best suit their health needs – and their pockets.

12. Many consumers therefore look for professional assistance in making these choices. They will approach a broker to provide them with best advice in terms of the most appropriate medical scheme and benefit option to meet their needs. Once the member has joined a scheme, the member may wish to retain the services of the

[1] For the purposes of this document, "consumer" refers to an individual or an employer.
[2] These are medical schemes which are open to anyone to join – as opposed to restricted schemes, which typically limit membership to a particular employer group.

broker to provide ongoing service and advice in respect of that member's continuing relationship with the medical scheme

13. The key expectation of the consumer in seeking the services of a health broker is that the broker will provide unbiased and independent advice and assistance in the interests of the consumer.

14. Because of the complexity of the environment, and the dependence of consumers on the advice and assistance of brokers in respect of choice of medical schemes and utilisation of scheme benefits, medical schemes (and their commercial administrators) have an interest in incentivising brokers to provide biased advice in their favour.

15. For example, schemes and their administrators typically would have an interest in incentivising brokers to encourage young and healthy people to join their medical schemes, while discouraging older and less healthy people from joining of remaining on their schemes.

16. The advice of a broker purporting to provide independent advice to a consumer, while being influenced by financial or other incentives to favour the interests of one or more medical schemes, is tainted by conflict of interest. In these circumstances, consumers would be at risk of being influenced to accept the advice of a broker which is not necessarily in their interest.

17. Unless the playing fields are leveled, medical schemes and their administrators are also at risk of being "held to ransom" by brokers who may influence consumers in favour of the medical scheme which pays the highest incentives.

The current regulatory framework

18. The current regulatory framework for broker remuneration in terms of the Medical Schemes Act, 2008, was last amended in 2004.

19. This framework endeavoured to "level the playing field" between medical schemes. Key features of the regulatory framework[3] include:

19.1. a prohibition on brokers receiving compensation for broker services unless they are accredited with the Council for Medical Schemes (to ensure regulatory oversight of the conduct of brokers and effective sanction, when required);

19.2. a regulated ceiling on commissions payable by medical schemes of a specified rand amount or 3% of a member's contributions, whichever is the lesser so (to ensure limits to which medical schemes could incentivise brokers to provide biased advice in favour or their products over the products of other medical schemes);

19.3. a requirement that brokers should only be remunerated by medical schemes or consumers themselves (to prevent circumvention of the commission limitations by, for example, so-called co-administration agreements with administrators);

19.4. prohibition of the payment of up-front commissions and removal of any differentiation between commission for admission of a member and ongoing services (to diminish incentives to unnecessarily switch members between medical schemes);

19.5. to the extent that a medical scheme pays commission to a broker, a requirement that this should be done in terms of a contract with the broker (to ensure that the arrangements are formalized and prevent "under the table" deals); and

[3] Section 65 of the Medical Schemes Act, 1998, read with Regulations 28 to 28C.

19.6. a requirement on medical schemes to immediately discontinue payment to a broker in respect of services rendered to a particular member if the medical scheme receives notice from that member (or the relevant employer, in the case of an employer group), that the member or employer no longer requires the services of that broker.

Problems with the current regulatory framework

20. After some years of working with this regulatory framework, it is clear that it remains problematic for a number of reasons.

21. First, difficulties arise from the fact that a medical scheme's expenditure on commission payable to brokers is spread across all the members of the medical scheme. Irrespective of whether or not a member makes use of the services of a broker, she or he pays the same medical scheme contribution.

22. This makes members price insensitive to the cost of broker services. Members have no financial incentive to notify the medical scheme to terminate the payment of broker commissions if they no longer require the services of the broker or if they are receiving substandard service or no service at all from the broker.

23. This problem is sometimes exacerbated by the fact that brokers are often initially appointed by employers, and commissions are then paid by the medical scheme from contributions made in respect of all the employees (who did not necessarily even have a hand in the appointment of the broker).

24. The result is that a broker who signs up a member of the medical scheme and then provides no further ongoing service to the member would potentially continue receiving ongoing commission indefinitely in respect of that member as a default if the scheme is not advised that the broker is not providing satisfactory service or any service at all.

25. This raises serious questions about whether medical schemes and their members are receiving value for money for the R1 billion (2007 terms) annually being spent on brokers – and whether the 10000 plus accredited health brokers and brokerages are all providing ongoing service levels to justify the commission being paid.

26. Secondly, enforcing commission payment ceilings has become very difficult as all sorts of new marketing-type arrangements have been entered into with medical schemes. Fees are then channeled to brokers in a manner which is very difficult to control or to differentiate commission payments from other forms of structured fees through intermediary entities. Policing these arrangements has therefore become relatively ineffectual, and the possibility of financial and other incentives being paid to brokers outside of the regulatory framework is very real – raising issues of conflict of interest in the advice rendered to consumers.

27. Thirdly, independence of advice is also compromised by the fact that brokers are contractually beholden to medical schemes as a condition for payment of commissions. If brokers act in a way which is perceived to be hostile to, or not in the interests of a medical scheme, they run the risk of their contract with the medical scheme being cancelled and thereby becoming ineligible for payment of commission from that medical scheme.

28. Fourthly, the current regulatory framework for brokers in terms of the Medical Schemes Act fails to make a distinction between brokers who provide services as independent agents of members and brokers who provide services as agents of medical schemes.[4] Under these circumstances, it is very difficult for consumers to

[4] In terms of section 1 of the Medical Schemes Act:

"broker" means a person whose business, or part thereof, entails providing broker services, but does not include—

(i) an employer or employer representative who provides service or advice exclusively to the employees of that employer;

(ii) a trade union or trade union representative who provides service or advice exclusively to members of that trade union; or

know whether the advice being obtained is independent advice in their own interests, or marketing advice on behalf of particular medical schemes. This leaves consumers in a quandary as to where to go if they want truly independent advice and assistance.

Principles for revising the regulatory framework

29. The regulatory framework is clearly in need of further revision to deal with these difficulties. Before we discuss the actual proposals for regulatory form, it is important to formulate certain principles or objectives that we would hope the new regulatory framework would achieve.

30. First, it is important that brokers purporting to provide independent advice and assistance to consumers should do so without conflict of interest and without fear of punitive response from medical schemes.

31. Secondly, if at all possible, this should be achieved without regulated ceilings on fees – which require considerable policing and can relatively easily be circumvented.

32. Thirdly, value-for-money can only be achieved if consumers who wish to make use of an independent broker service pay for that service, while consumers who do not wish to make use of a broker service do not pay for the service.

33. Fourthly, medical schemes compete with other medical schemes, and therefore have a distinct and legitimate interest in marketing their schemes to consumers (provided

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(iii) a person who provides service or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of a medical scheme,
unless a person referred to in subparagraph (i), (ii) or (iii) elects to be accredited as a broker, or actively markets or canvasses for membership of a medical scheme;

"broker services" means—

(*a*) the provision of service or advice in respect of the introduction or admission of members to a medical scheme; or

(*b*) the ongoing provision of service or advice in respect of access to, or benefits or services offered by, a medical scheme.

that a consumer can clearly discern the distinction between a marketing agent and a broker providing independent advice).

The proposed solution

34. The proposed solution lies in making a clear distinction in the legislation between brokers who act as agents of the scheme and brokers who act as independent agents of consumers. For purposes of this document, we will refer to them as "marketing agents" and "independent advisors" respectively.

35. It is proposed that brokers should be accredited with the Council in terms of the MSA as one or the other (and not both) – because the issue of potential bias and conflict of interest is not resolved by the same person "wearing different hats" in different circumstances.

36. Once this distinction is made, the one-size-fits-all approach to regulation can be fine-tuned to regulate the two categories of brokers separately (which would also include treating remuneration of these brokers differently from a regulatory perspective).

Marketing Agents

37. As mentioned above, medical schemes operating in a competitive environment have a legitimate interest in marketing their schemes to potential new members.

38. A marketing agent of a medical scheme would obviously be required to provide truthful and factual information to the consumer about a product, but would not be expected to be impartial vis-à-vis other medical schemes. There is nothing inherently wrong with this, provided that the consumer is under no illusion that what is being offered is impartial, independent advice and assistance.

39. The same would apply in any other market. A consumer knows that when a Telefunken television salesperson knocks on the door, one can hardly expect the salesperson to extol the virtues of a Sony. It may be useful to hear from the salespersons what the price and features of the Telefunken are, but a wise consumer would then go and compare this information with that of other brands before making a decision on which TV set to purchase.

40. Marketing agents are agents of the medical scheme concerned (effectively its sales force). This is part of their normal course of business, and is a legitimate expense of the medical scheme. However, a consumer who receives advice from a marketing agent would have no reason to pay a premium for this advice over and above what everyone else is paying.

41. If marketing agents marketed a range of medical schemes, there would remain an incentive on the scheme or its administrator to bias advice and information in favour of its own medical scheme. As a consequence, medical schemes would still "outbid" each other through the provision of financial and other incentives. Medical schemes could also still be "held to ransom" by unscrupulous brokers threatening to move members if they weren't paid more than other medical schemes. Non-health costs would therefore be at risk of rising without corresponding value for money.

42. However, if the marketing agent only marketed a single scheme, the scheme or its administrator would have no incentive to "outbid" other schemes in financial incentives to the agent in order to influence the advice of the agent in its favour. The scheme would have no incentive to pay more than what the service is worth to that scheme – and there would be no need to cap the amount paid by the medical scheme.

43. It is therefore proposed that marketing agents of medical schemes should:

    43.1. be accredited to be the agents of only one medical scheme at a time (and be prohibited from being the agents of any other medical scheme);

43.2. be paid by the medical scheme concerned (and not by the administrator or any other party which may have an interest in marketing any other scheme);

43.3. operate in terms of a written contract with that medical scheme, which contract may provide for various remuneration types (e.g. salary, commission etc);

43.4. not be subject to regulated ceilings on remuneration payable by the medical scheme; and

43.5. be required by law to clearly state to the consumer verbally and in writing that he or she is a marketing agent of a medical scheme – and is not an independent advisor.

Independent Advisors

44. Consumers (individuals or employers) wishing to receive independent advice and assistance vis-à-vis choice of medical scheme and/or ongoing relationship with their medical schemes, should be able to purchase that service independently of the medical scheme.

45. As with any other service provider, if the consumer sees value in the service, the consumer should be prepared to pay for the service. If the consumer perceives that she or he is no longer receiving value for the service, he or she will not continue paying for the service and will terminate the contract. These independent advisors would therefore operate in terms of a contract negotiated with the consumer, based upon an agreed upon tariff.

46. To be consistent with the principle in the employment context, if the party appointing and contracting with the independent advisor is an employer, the employer would pay for the services of the advisor. If the party appointing and contracting with the independent advisor is an employee, the employee would pay for the services.

47. This requirement to pay for the services of an independent advisor, while consumers not making use of the service are not required to pay for these services, will ensure that value is provided for money spent on independent health advisors – and that the flow of funds to advisors terminates if the advisors stop rendering a satisfactory service or any service at all.

48. To prevent advice and assistance being tainted by conflict of interest, the independent advisor would not have any contract with any medical scheme or administrator and would not be able to receive any form of remuneration or incentives for broker service or any other type of service directly or indirectly from a medical scheme or administrator. There would be no possibility of schemes or administrators paying extra to bias advice being rendered by these advisors.

49. Under these circumstances, there would be no need for a regulatory ceiling to be placed on the amounts that may be charged by independent advisors for their services. The market would dictate what is charged, based upon the quality of the service being rendered.

50. However, there would still need to be some regulation of how these payments are structured. For example, if one allowed upfront commission to be charged on admission of a member to a medical scheme, it would still incentivise brokers to churn members between medical schemes and would not encourage ongoing services to be provided. It would therefore be necessary to retain the restriction that no differentiation should be made between the fees charged for admission of a member and fees charged for ongoing services.

51. It is recognised that while the requirement for independent advisors to collect fees directly from clients would be easily done in relation to clients who are employers, it may disincentivise brokers to work within the market for individual members because of the cost of collection when weighed up against the relatively small amounts being collected monthly for services rendered.

52. However, this is no different from other service sectors where relatively small fees are charged but to a potentially high volume of clients. Independent advisors would be able to outsource their debt collection services to debt collection agencies that have the economies of scale to manage such a service.

53. The suggestion has, however, been made that medical schemes themselves could perform this role of collecting fees payable in terms of contracts with independent advisors on their behalf (potentially at an administration fee). The suggestion is that this service could be provided for individual clients, but not employers.

54. This option is not favoured because debt collection is not the business of a medical scheme, non-health costs would likely rise to accommodate this service, and it would again potentially blur the line of independence between the advisor and the medical scheme. However, comment is also invited on this option.

Fidelity Insurance

55. Due to the agency relationship between medical schemes and their marketing agents, it is clear in common law that the medical scheme remains liable for the advice rendered by its marketing agents.

56. Making this explicit in the legislation will encourage medical schemes to exercise greater quality control over the advice and information provided by its agents. This also has the effect that there is no need for a legislative requirement that marketing agents must take out their own fidelity insurance.

57. On the other hand, due to the independence of independent advisors from medical schemes (and the potentially significant damages that can accrue to members in the event of poor or negligent advice), there is a need for a legislative requirement that independent advisors must take out adequate fidelity insurance.

Summary

58. A summary of the key differences between the proposed regulation of marketing agents and independent advisors is set out in the table below.

	Marketing Agent of Medical Scheme	**Independent Advisor**
Interests being served	Medical scheme	Consumer (individual or employer)
Requirement for accreditation	Yes, as marketing agent	Yes, as independent health advisor
Party with whom contract is entered	Medical scheme	Consumer
Single or multiple contracts	Single contract with only one medical scheme	Contracts with multiple consumers
Source of remuneration	Medical scheme	Consumer
Ceiling on remuneration	No	No
Form of remuneration	As per contract	As per contract, subject to prohibition on upfront commission
Consulting and other services provided to medical schemes, administrators and related entities	Unrestricted	Prohibited
Disclosure requirements	Written and verbal disclosure to clients of status as marketing agent of a particular medical scheme – and disclosure of any conflict of interest material to the transaction	Written and verbal disclosure to clients of status as independent advisor – and disclosure of any conflict of interest material to the transaction
Party held liable for advice	Medical scheme	Independent Advisor
Requirement for fidelity insurance	No	Yes

Impact of the reforms

59. The impact on the market will be significant, changing the way in which schemes are marketed, and the influence members will have over schemes through their choices.

60. Ensuring the impartiality of advice provided by independent advisors, will improve the quality of the advice provided to members. It is likely that schemes will continue to value these advisors, but will in future engage with them on an arms-length basis.

61. The proposed restructuring will cut across existing practices in the market, with significant financial implications for some players. However, this restructuring will remove perverse and uncompetitive practices in the existing market.

62. The essential gain from this set of reforms will be the creation of a truly competitive open scheme market, with schemes having to demonstrate value to informed members. This will consequently impact on the quality of offerings and their pricing, including non-health expenses.

Process Forward

63. Once comments have been received they will be evaluated and an assessment with recommendations will be placed before the Council for its consideration.

64. The Council, in its discretion, may then make recommendations to the Minister of Health for revisions to the existing legislative and regulatory framework. This is consistent with its function in terms of section 7(g) of the MSA to advise the Minister on any matter concerning medical schemes.