

CMS news

Issue 1 of 2010-2011

**What
medical
schemes
are all
about**

Guaranteed
benefits

Equalised
risks

All pay
the same

All
welcome

Governance



South Africans have many things to be proud of. Our medical schemes industry should be one of them.

Ten years ago an improved legislative foundation for private health cover was laid and it is solid – and it protects you and us against unforeseen health events that could have proven catastrophic to our livelihoods had medical schemes not been around. The provisions on open enrolment, community rating and prescribed minimum benefits make the Medical Schemes Act 131 of 1998 a unique piece of legislation worldwide.

The fourth pillar of the Act – governance – will always be relevant, particularly to trustees.

Now, if only a system of risk adjustment were in place, the picture would be complete – and we would have achieved the goal of eliminating all forms of discrimination plaguing private health insurance.

Thankfully, a comprehensive review of the legislative framework is currently underway to address the inevitable imperfections of a concept as complex health insurance. This we should also be proud of.

Editorial Committee

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The heart of the matter

For the Medical Schemes Act to have meaning, this is what the purpose of medical schemes must be.

The Medical Schemes Act requires that medical schemes act positively to the challenges of member protection and fair treatment. These ideals are achieved by ensuring open enrolment, community rating, improving access to prescribed minimum benefits and the promotion of good governance, which are the heart of the Medical Schemes Act.

The Medical Schemes Act promotes equity of access for members of medical schemes and emphasises cross-subsidisation between the high- and low-risk profile members and between low and high earners. The underpinning principle of cross-subsidisation is that the cost burden of a few is borne by many. This notion is directly linked to the issues of affordability and sustainability of the medical schemes industry.

The business of a medical scheme – the purpose of the definition

What is a medical scheme?

This is the question that drafters of the Medical Schemes Act asked themselves back in 1998.

They decided on the following:

“[The] ‘business of a medical scheme’ means the business of undertaking liability in return for a premium or contribution:

- (a) to make provision for the obtaining of any relevant health service;
- (b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- (c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.”

But what does this mean?

Point (a) in the definition means that medical schemes must provide healthcare benefits, including a prescribed package of minimum benefits for healthcare needs. The uncertainty attached to your health poses a number of risks for your medical scheme; the most obvious risk to you is the loss of health itself. This is why medical scheme members buy benefit packages based on their

need for healthcare – and why medical schemes are structured in a way that makes them financially sustainable in the long run.

Point (b) in the definition means that monetary contributions are paid in exchange for healthcare benefits. Members of medical schemes have the obligation to pay a relevant contribution which entitles them to access a defined benefits package. Members are encouraged to read up on their rights and responsibilities when accessing benefits, specifically the prescribed minimum benefits or PMBs.

Point (c) in the definition means that medical schemes are allowed to contract with service providers for the provision of comprehensive benefits, including out-of-hospital benefits and PMBs.

In summary, the point is to ensure that members of medical schemes are protected against an unforeseen health event which may have proven financially catastrophic had the medical scheme not provided the necessary cover.

But the business of a medical scheme, as defined in existing legislation, makes sense only if the following principles are also enshrined in the Medical Schemes Act: open enrolment, community rating, PMBs, governance and a system or risk adjustment or risk equalisation. Each of these is discussed in subsequent articles in this issue of CMS News.

How the Act protects members of medical schemes

The definition of the business of a medical scheme, as in the Medical Schemes Act 131 of 1998, was always meant to guide medical schemes on the type of services required to be provided to members in order to operate as a registered medical scheme.

The definition was tried in the High Court in 2008 when the Guardrisk product was interrogated for its structure and way of operating. The judgement resulted in an interpretation on the reading of the definition, not an interpretation on the definition itself.

But the harm had been done. The judgement

By **Daisy Ditshoene** (SENIOR ANALYST: BENEFITS MANAGEMENT), **Paresh Prema** (HEAD: BENEFITS MANAGEMENT) & **Aleksandra Serwa** (COMMUNICATIONS MANAGER)

“The current situation poses numerous problems for the integrity of the health insurance industry in our country.”

Continued on page 16

Open enrolment: then and now

“Open enrolment” is a key provision in the Medical Schemes Act. Coupled with community rating and prescribed minimum benefits, it speaks to the very heart of what the South African medical schemes industry is all about.

By **Thembekele Phaswane** (SENIOR MANAGER: COMPLAINTS ADJUDICATION) & **Brenda Lissner** (SENIOR ANALYST: BENEFITS MANAGEMENT)

What is open enrolment?

Open enrolment is a social security principle set down in law which requires every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme.

Put differently, one of the statutory objectives of the Medical Schemes Act is to ensure non-discriminatory access to private healthcare financing – and this objective is achieved through open enrolment.

Section 29(3)(a) of the Medical Schemes Act is clear; it stipulates that “[a] medical scheme shall not provide in its rules for the exclusion of any applicant or a dependant of an applicant, subject to the conditions as may be prescribed, from membership, except for a restricted membership scheme as provided for in this Act”.

The effect of this provision is that every person who applies for membership as well as any member who applies for the membership of a dependant, is guaranteed membership of an open medical scheme.



The Medical Schemes Act is succeeding in its intention to protect non-discriminatory access to medical schemes.

And applicants must be accepted into the scheme regardless of factors such as their age or past and present medical history.

The Council for Medical Schemes, regulator of the industry, is entrusted with the responsibility of enforcing the Medical Schemes Act and consequently not registering a medical scheme that could possibly unfairly discriminate, directly or indirectly, against applicants or existing members and dependants on arbitrary grounds. The arbitrary grounds spelled out in Section 24(2)(e) of the Act include race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

Who needs it?

Few will oppose the idea that we all have the right to access quality care and that this right should not be denied based on arbitrary grounds. But there are others who do not seem to share this

point of view. Those against open enrolment are of the opinion that the provision exposes medical schemes to unlimited risks as they are not allowed to decline the membership of applicants who are sick and/or old. But this argument has never been substantiated. Moreover, the law aims to be fair; medical schemes are allowed to use waiting periods and late-joiner penalties (discussed below) to protect their financial stability and long-term sustainability. Both these mechanisms have proven effective.

Implications for beneficiaries

Now that you have access to the open medical scheme of your choice, whether as a principal member or a dependant, you have the responsibility not to misuse or abuse the privileges being offered on the basis of you having been allowed into the scheme.

If there is evidence of misuse of benefits (including fraud committed against the scheme), the medical scheme does have the right to resort to the remedies provided for in the Medical

Schemes Act and its registered rules. Those remedies are either suspension of membership or termination (cancellation) of membership (with retrospective effect).

The legal implication of having your membership suspended is that you will still be obliged to pay your monthly contributions but without enjoying any benefits during the period of your suspension. The legal implication of having your membership terminated or cancelled is that you will be refunded all the contributions that you have paid from the date of joining the scheme and the medical scheme will reverse all the claims it had paid on your behalf during the period of your membership.

Implications for medical schemes

Now that open medical schemes have no choice but to accept all applicants, they also have the responsibility to treat all their members the same way. Equal and fair treatment can be achieved by being consistent in imposing waiting periods and late-joiner penalties. As mentioned above, medical schemes have the right to protect themselves against the risks posed by their members by imposing certain terms and conditions of membership; these include the imposition of waiting periods and late-joiner penalties. These risk-mitigating measures are fundamental to the financial sustainability of medical schemes.

And if we didn't have open enrolment?

Historically, medical schemes were restricted or employer-based. Open medical schemes emerged only in the 1980s. But they were not obliged to accept all applicants; instead they would cherry-pick preferred profiles which were regarded as “non-risky” and decline membership of the aged



The provision of open enrolment, together with the principle of community rating and the package of prescribed minimum benefits, ensures that the sick and old are protected too.



and the sickly. True open enrolment only came about with the Medical Schemes Act 131 of 1998 which came into operation on 1 February 1999.

A law aimed at ending unfair discrimination in the health context was finally in place, but it was not welcomed by all; the medical schemes industry did not embrace open enrolment and applicants were still being prevented from becoming members of open medical schemes way after the Medical Schemes Act came into effect.

What happens today

The Complaints Adjudication Unit at the Council for Medical Schemes continues to handle cases where medical schemes make it unnecessarily difficult for applicants to sign up as members or dependants.

We see proof of unreasonably long delays in finalising applications for membership and in some instances documentary evidence of schemes blatantly refusing to accept applicants, with some imposing waiting periods in contravention of the provisions of the Medical Schemes Act.

The tactics being employed by some medical schemes are meant to unlawfully exclude applicants (as well as members and dependants) from access to benefits which they are legally entitled to. Such tactics also aim to delay the finalising of membership with the objective of getting applicants to be covered elsewhere.

Equally illegal and unacceptable is the conduct of those brokers who abuse the open enrolment provision by merely churning members between schemes without offering them any real value for money.

But members and applicants can also get it wrong. The Council for Medical Schemes has attended to cases where members attempted to enrol their grandchildren who were not eligible for membership. ■

Distinguish between open and closed schemes. Closed schemes are also called restricted schemes and are employer-based. The open enrolment provision does not apply to closed schemes. At the end of 2009, there were 33 open and 77 closed schemes registered in South Africa.

Before 2000 (no true open enrolment)

Applicants could be refused membership based on various arbitrary grounds, including age, health status/medical history.

The trustees of a medical scheme had the power to accept or reject an application, and limit and/or exclude benefits for a particular illness, disorder or disability which existed at the time of admission as a member or dependant.

No limitation or exclusion in respect of congenital conditions could be imposed on a child born into the scheme.

After 2000 (true open enrolment)

Membership to an open medical scheme may not be refused on any grounds.

Certain criteria must be met before one can join a closed/restricted medical scheme, such as being formerly or currently employed in a particular trade, profession or industry.

Community rating: then and now

The principle of community rating ensures that the contribution you pay to your medical scheme is fair.

By **Mpho Sehloho** (SENIOR ANALYST: BENEFITS MANAGEMENT), **Mashilo Leboho** (SENIOR ANALYST: BENEFITS MANAGEMENT), **Brenda Lissner** (SENIOR ANALYST: BENEFITS MANAGEMENT) & **Paresh Prema** (HEAD: BENEFITS MANAGEMENT)

Community rating refers to the practice of charging a contribution to all members on a specific benefit option within a medical scheme that does not discriminate against them unfairly.

In other words, all members on a particular option must by law pay the same contribution, regardless of their age or health status or any other arbitrary ground.

Community rating is the opposite of risk-rating where the latter distinguishes between "high risks" and "low risks" and charges you more if you are more likely to claim a benefit and therefore a "high risk" to the insurance company.

Medical schemes are prohibited from risk-rating by Section 29(1)(n) of the Medical Schemes Act. It states:

"The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed."

Put simply, risk-rating or the varying of contributions on the basis of age, gender, state of health, frequency of rendering health services and/or any other arbitrary ground is illegal. Legislation only permits differentiation in contributions on the basis of income and/or family size.

In an unregulated environment governed only by market forces, medical scheme contributions would be based on your "risk profile". Markets where risk-rating is allowed are characterised by "cherry-picking" behaviour targeting the younger and healthier members of the public while sicker members

are penalised (unfairly) by being charged higher contributions.

The benefits of community rating include:

- Considerable cross-subsidisation between low-risk and high-risk individuals ensures that all members on a benefit option pay the same contribution for the same benefits but access benefits based on what they need.
- Even the most vulnerable members enjoy affordable access to healthcare and are protected against the potentially catastrophic effects of an illness and/or medical expenditure.
- Medical schemes are prevented from "cherry-picking" good profiles (thanks to the principle of open enrolment).
- Price discrimination against people with high-risk medical condition(s) is prevented (they would have been excluded in a risk-rated market).

If community rating did not exist

The deregulation of the medical schemes industry in 1989-1999 saw the return of risk-rated contributions or price discrimination. Medical schemes were allowed to link contribution rates to your risk profile, including your age, health status and claim history. They incentivised low-risk members to enrol while discouraging people with chronic conditions from entering the private insurance market.

Predictably, many open schemes embarked on a process of risk selection. To gain an advantage over their competitors, open schemes did their best to deny coverage to anyone who might need medical care because they were considered "high risks". This practice was clearly evident in the scheme rules and marketing material submitted to the Council for Medical Schemes.

During the time of deregulation people with chronic condition(s) were charged higher contributions which meant that private healthcare was unaffordable to the vulnerable members of the public who needed medical care the most, namely the sick and the elderly. The so-called high-risk members were left to market forces and pushed onto the public sector. This was neither fair nor equitable; regulatory intervention was required.

An undesirable consequence of a risk-rating environment was a skewed market structure char-

acterised by inequalities, inefficiency, insolvency and liquidation as some medical schemes benefited unfairly from picking low-risk members while others experienced worsening demographic profiles.

Legislative reforms in 2000, as incorporated in the Medical Schemes Act 131 of 1998, reintroduced the principle of community rating and put an end to an 11-year filtration with the unfair practice of price discrimination in the South African private healthcare sector.

Current practice

The implementation of community rating currently prescribed by law applies to the price of each benefit option in each medical scheme rather than the medical scheme as a whole. Consequently, medical schemes are required to design their benefit options in such a way that each benefit option operates as a separate and distinct risk pool for community rating.

Section 33(2)(b) of the Medical Schemes Act requires each benefit option to be self-sustaining, thus forcing risk-pooling to occur at option level. The high degree of product differentiation in the market suggests that variation in contributions reflects the differences in the risk characteristics of the individuals choosing them.

The industry has been very dynamic and innovative when it comes to benefit design, which to date has been within the bounds set out in the Medical Schemes Act. The Council for Medical Schemes remains committed to ensuring that the requirements of the law with respect to benefit design are complied with and that the flexibility allowed does not induce risk-rating. Without the CMS overseeing the industry, an opportunity for risk selection may arise.

But in a community-rated environment without a risk equalisation mechanism in place, there will

always be the challenge in the open schemes environment where schemes with a lower risk profile have a competitive advantage and thus a strong incentive to use benefit design to risk-select.

Future legislation will aim to enhance community rating within medical schemes themselves – and possibly within the industry as a whole. This would be the next logical step in the evolutionary nature of healthcare provision in South Africa.

For the benefit of society

Members of medical schemes are protected against unfair discrimination by schemes as they cannot be denied entry to medical schemes (open enrolment) and contributions are not determined based on their risk profiles (community rating).

Efficiency should be attained in the market where medical schemes compete on the cost-effectiveness of their services rather than on the risk profiles of their membership.

With the current structure of the industry and legislation, it is imperative that medical schemes no longer be allowed to compete on the basis of risk selection (the age and health of the members they attract) but instead on the basis of providing the most cost-effective healthcare for the benefit of society. ■

“The principle of community rating ensures that the contribution you pay to your medical scheme is fair.”

Community rating then and now

Before 2000

Contributions could be determined on any number of arbitrary grounds, including your age, the claims history of the member and/or a specific group of members, your income, the number of dependants, the area in which you lived and/or your period of membership with the scheme.

After 2000

Contributions may be based only on your income and/or number of dependants.

Efficiency discounts

Benefit options with efficiency discounts offer members discounts where the scheme is able to obtain efficiency with a provider network. The main purpose of the discount is to offer members a more efficient choice of providers while continuing to offer contributions that are not discriminatory.

Although such options allow a form of price discrimination in conflict with community-rating legislation, schemes can apply for exemption to operate such options. Efficiency-discounted options allow schemes to negotiate better reimbursement and healthcare delivery terms with providers. This arrangement normally results in cost savings for schemes.

Prescribed minimum benefits: then and now

The package of guaranteed healthcare benefits has been around for over a decade, yet it remains a sensitive subject. We take a closer look at prescribed minimum benefits, a pillar of the Medical Schemes Act.

By **Dr Nonkululeko Mlaba** (former CLINICAL ANALYST with the Council for Medical Schemes) & **Brenda Lissner** (SENIOR ANALYST: BENEFITS MANAGEMENT)

The medical schemes industry dates back to more than 100 years ago when mining house De Beers formed the first medical scheme in 1889.

Two pieces of legislation, namely the Friendly Societies Act of 1956 and the Medical Schemes Act of 1967, formalised the status of medical schemes, with the latter making provisions for the community rating of contributions and guaranteed minimum benefits. Amendments to the Act in 1993 resulted in radical deregulatory reforms which allowed schemes to risk-rate their cover and exclude “medically uninsurable” people. This also led to the exclusion of vulnerable low-income groups from cover and high cost increases.

The newly elected government in 1994 inherited a private healthcare system that had turned in the direction of mutuality. The re-regulation of the private sector – based on solidarity principles, more equity across different population groups and the fairer competition between schemes – occurred with the promulgation of the revised Medical Schemes Act 131 of 1998. This saw the reintroduction of three key principles:

- open enrolment: open medical schemes have to accept anyone who wants to become a member (at standard rates);
- community rating: everyone must be charged the same rate, regardless of their age or state of health; and
- prescribed minimum benefits (PMBs): all schemes must cover in full a minimum package of benefits from the pooled benefits of the scheme.

Prescribed minimum benefits

Now that these three pillars of the Medical Schemes Act are in place, this means that each scheme has to pay for a mandatory PMB package from its risk pool in which contributions are made on the basis of family size and/or income only. The PMB package extends the social security net to vulnerable groups, ensuring that access to healthcare and protection from catastrophic

out-of-pocket expenditure is not their sole responsibility, by compelling the funding of the PMB package from the common risk pool of the scheme.

As part of initial research conducted on PMBs, two papers examined various objectives that could inform the development of an essential healthcare package in South Africa. They listed the potential objectives as:

- facilitating catastrophic insurance cover;
- ensuring risk-based cross-subsidies;
- improving allocative efficiency;
- reducing the burden of disease;
- improving equity;
- controlling moral hazard and cost escalation;
- fostering competition; and
- facilitating transparency and participatory democracy.

By first defining a hospital-based diagnosis and treatment combination (PMB-DTPs or Diagnosis and Treatment Pairs) and specifying that medical schemes have to pay for them in full, the aim of government was to generate resources for the public health sector which had, as a result of the deregulatory changes in the 1980s, become the de facto last-ditch insurer; government also wanted to prevent medical schemes from referring seriously ill patients to the public sector. In addition, basing competition on one and the same PMB package was expected to generate efficiency gains.

The above is echoed in the objectives contained in the Explanatory Note under Annexure A of the Regulations promulgated under the Medical Schemes Act; PMBs are specified:

- to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals; and
- to encourage improved efficiency in the allocation of public and private healthcare resources.

The PMB-DTP component was designed and

priced based on:

- the exclusion of services for which other parties are responsible;
- cover for specific diseases, especially those where severity may necessitate hospitalisation;
- the degree of urgency for the condition (thus discretionary treatments were excluded); and
- the cost-effectiveness of the treatment.

The initial essential healthcare package thus consisted of 270 hospital-based Diagnosis and Treatment Pairs (DTPs) adapted from the Oregon Health Plan Administration benefit descriptions. Regulations were amended in 2002 to include cover for emergency medical conditions and an out-of-hospital treatment component, and 25 chronic conditions in 2004 (PMB-CDL or Chronic Diseases List). The benefits for chronic conditions include cover for the diagnosis, management and medicine according to therapeutic algorithms published in the Government Gazette.

The reason for the amendments was that many medical schemes had excluded out-of-hospital cover for chronic conditions when the PMB package was implemented in 2000; some schemes had also significantly reduced their chronic medicine benefits, making themselves less attractive to older and sicker members. That way benefits for chronic conditions had become an effective tool for risk-selection. Before the PMB-CDL was introduced, benefit design and managed care tended to focus on chronic medicine only, without taking an integrated approach. The aim of the CDL is to ensure that all beneficiaries have access to in- and out-of-hospital benefits for the diagnosis, treatment and care of certain common chronic conditions.

The Medical Schemes Act allows schemes to use managed care techniques – including pre-authorisation, formularies and provider networks – to manage the financial risk resulting from PMBs. Schemes can levy co-payments if a member chooses to use a provider who is not a designated service provider (DSP).

The PMB package consists of a range of benefits meant to cover risks that could jeopardise

an individual's livelihood had no insurance existed. The package is limited to a reasonable and socially acceptable minimum level of care, delivered efficiently and in compliance with evidence-based medicine, cost-effectiveness and affordability principles.

Have prescribed benefits worked?

PMBs have been in place for more than a decade, yet few schemes have tracked the cost or expenditure of this package. In addition, very few schemes are able to isolate PMB expenditure from other benefits. There is also evidence that some schemes continue to risk-rate through benefit design; this is shown by a decline in the coverage of non-CDL conditions in order to avoid attracting older and sicker members.

But some schemes are showing signs of being loaded with high-risk or high-cost beneficiaries unrelated to mismanagement or inefficiencies which, in the absence of other policy measures (such as risk equalisation, mandatory insurance cover and income cross-subsidies), is counter to the above-stated objectives of PMBs.

One of the biggest challenges which have plagued PMBs is the lack of clarity on the entitlements of the DTP component. Each disease listed in the DTP defined by Söderlund and Peprah in 1998 included an ICD (International Classification of Diseases) code and related treatments, as listed by their CPT4 procedure code. This approach ensures that there is no doubt as

“The package of prescribed minimum benefits extends the social security net to vulnerable groups.”

PMBs then and now

Before 2000	After 2000
Numerous benefits were excluded, e.g. costs in respect of third-party claims, expenses incurred by a beneficiary in the case of a self-inflicted injury, treatment for infertility and HIV/Aids, professional sport injuries and alcohol abuse.	Most conditions which were previously excluded now fall under the PMBs and may no longer be excluded, e.g. HIV/Aids; PMBs have been expanded to include the treatment of medical emergencies.

Governance and medical schemes

There are two sets of legal principles that should underpin the behaviour and all decisions of Boards of Trustees: the principles contained in medical schemes legislation, and common law principles binding all persons in positions of trust.

In this article we focus on medical schemes legislation, but we also look at proposed enhancements to the current regulatory system. We point out where common law principles and other legal and regulatory frameworks complement the Medical Schemes Act and its Regulations.

The Medical Schemes Act Appointments

Section 57 of the Medical Schemes Act governs the appointment of trustees. It requires that at least 50% of the Board be elected from amongst members of the scheme. The Act contains no details as to how such an election should take place, but Section 29(1) states that the election and appointment of trustees should be set out in the rules of the scheme.

The model rules published by the Council for Medical Schemes (CMS) provide for a process of nominations and the submission of CVs, and that the election should take place at an Annual General Meeting of the scheme. Nothing prevents schemes from setting out in more detail how elections should be run in line with the general principles of fairness and transparency, and, for example, establishing a committee to look into compliance of nominees with the "fit and proper" criterion.

To qualify as a member of the Board, the person has to be "fit and proper" to manage the affairs of the scheme. The Registrar of Medical Schemes can remove a trustee from office if s/he is found not "fit and proper".

In a draft standards document (issued for comment in October 2008), the CMS defines "fit and proper" as the eligibility to hold an important position of trust, where fitness refers to a person's competence and ability, and being "proper" refers to a person's character and integrity. The CMS proposes that "fit and proper" include financially sound; honest, reputable and reliable; and competent to perform the role in question.

The phrase "fit and proper" appears in many other laws, and specifically in connection with persons who are expected to act in the public interest.

This criterion includes persons with the "knowledge, qualifications or experience" to fulfil the specific role (Constitution) or persons characterised for their "independence, impartiality and

fairness, and who further are suitable for membership by reason of their understanding of and expertise in or knowledge of" a particular sector (National Land Transport Transition Act).

Financial duties

Section 37 of the Medical Schemes Act requires of the Board to cause annual financial statements to be prepared, which have to be submitted to the Registrar with a Board Report. The Board also has to appoint an audit committee of at least five members, of which at least two shall be members of the Board. The Act contains detail-provisions as to how an auditor should be appointed (Section 36). Chapter 7 sets out in detail the aspects which form part of the duty to ensure that the financial affairs of the scheme are managed properly and in line with legal criteria. Trustees also have to "take all reasonable steps to ensure that contributions are paid timeously to the medical scheme in accordance with this Act and its rules" (Section 57(4)).

The financial statements of the Board should, in terms of Section 37(5), also include a report dealing with every matter which is material for the appreciation by members of the scheme of the state of its affairs and business and the results thereof, and information indicating whether the resources of the scheme have been applied economically, efficiently and effectively.

Other duties

The top five duties of trustees in terms of the Medical Schemes Act are:

- 1 Provide adequate and appropriate information to members.
- 2 Obtain expert advice.
- 3 Ensure compliance with the Medical Schemes Act and all other applicable laws.
- 4 Act with due care, diligence, skill and good faith.
- 5 Avoid conflicts of interest.

Section 57 sets out the duty of trustees to make appointments, including that of the Principal Officer and Committees such as the Audit Committee. In

to which ICD code and procedures form the benefit package. But the package adopted by government unfortunately excluded this key aspect. This omission has allowed medical schemes, administrators, healthcare providers and consumers to interpret PMBs differently. Related to this is the poor quality of coding which, despite being a legislated requirement in the private sector for the past five years, remains inadequate. Other challenges are the lack of awareness about PMBs by both providers and consumers, and poorly defined administrative processes. All these issues have contributed to non-compliance with the provisions of PMBs, prompting the regulator to issue a threat of punitive action against the offending schemes.

“
Prescribed minimum benefits have been in place for more than a decade, yet few schemes have tracked their cost.”

Solving the problem

Industry has met on several occasions. All stakeholders were represented: the relevant regulatory bodies (the Council for Medical Schemes, the Health Professions Council of South Africa), the Department of Health, medical schemes and administrators, healthcare providers and consumer advocacy groups. Everyone agreed to seek a coop-

erative and collaborative process with the aim of finding solutions to PMB-related problems. This led to the establishment of a PMB Task Team whose objective was to develop a code of conduct for PMBs to be offered to medical scheme beneficiaries in compliance with current regulations; this PMB code of conduct was published in July 2010.

The PMB code of conduct reiterates that the level of care for PMB conditions is not restricted to hospital-based management. The Council for Medical Schemes has also committed itself to coordinating a process aimed at developing benefit definitions which will explicitly state diagnostic tests, consultation visits, the appropriate setting and level of care as well as related procedure codes and drug treatments.

Measures have been proposed to improve the quality of coding; this will assist in identifying PMBs. The use of managed care tools such as pre-registration, applications and authorisations is encouraged to ensure that PMBs are paid from the appropriate benefits. It is also important to facilitate and promote the transparency of schemes' administrative processes.

Schemes have committed themselves to ensuring that adequately trained subject matter experts are available to both providers and members to facilitate access to PMBs; an escalation process for appealing funding decisions at scheme level will be communicated to providers and members alike and will be readily available via various communication channels.

Members of the PMB Task Team did not reach consensus on all areas in question. These have to do with the "payment in full" provisions of Regulation 8, the validity of expanding the PMB package to include more out-of-hospital components, and the practice of referring to the public sector as the benchmark for the level of care. The position of the Council for Medical Schemes is that these areas have been tested in our appeals process and our interpretation reflects the final rulings handed down. ■

Principles of PMB code of conduct

- Clarity and certainty on PMBs must be established.
- Information on PMBs must be more accessible.
- Communication guidelines must be developed and shared with medical scheme members frequently.
- Access to PMBs must be clarified.
- Terminology used in the industry must be standardised.
- The manner in which schemes apply managed care tools must be communicated.
- The accuracy of identifying PMB-related claims must be improved.

“
Governance is the glue that holds everything together.”

By **Elsabé Klinck** (HEALTH LAW EXPERT) & **Gugulethu Tlali** (LEGAL ADVISOR)

This is an opinion piece. The views expressed in this article do not necessarily reflect the views of the Council for Medical Schemes.

addition, it requires the keeping of proper registers, books, records and minutes, as well as "proper control systems".

Trustees also have to ensure that adequate and appropriate information is communicated to members regarding their rights, benefits, contributions and duties in terms of the rules of the medical scheme.

Since medical scheme rules and their implementation have to comply with the Medical Schemes Act (an explicit duty placed on trustees by the Act), communication to members on other aspects, such as managed care, has to be similarly "adequate" and "appropriate".

Members must be placed in a position to make an informed decision, and communications may not be false, misleading or deceptive.

In addition, Section 57 requires trustees to:

- take out and maintain an appropriate level of

professional indemnity insurance and fidelity guarantee insurance;

- obtain expert advice on legal, accounting and business matters as required, or on any other matter of which they may lack sufficient expertise; and
- take all reasonable steps to protect the confidentiality of medical records.

Section 57(6) requires trustees to take active measures to ensure that they:

- act with due care, diligence, skill and good faith;
- avoid conflicts of interest; and
- act with impartiality in respect of all beneficiaries.

It is not enough to affirm that trustees should act in this manner; active steps have to be taken to prevent, identify, manage and regulate conduct so

as to ensure compliance with these principles. This requires Boards to evaluate practical examples of conduct which necessitate due care, conflict avoidance and impartiality.

Conflicts of interest – beyond mere disclosure

Section 57(3) of the Medical Schemes Act prohibits one from becoming a trustee or Principal Officer if one is "an employee, director, officer, consultant or contractor of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator, or a broker".

But there may be more subtle forms of conflicts of interest, recognised by the common law fiduciary duties of trustees and the principles of administrative justice that should underpin all decision-making processes that affect the rights and interests of members.

Section 57(6) makes it clear that trustees have to ensure that the interests of members (in terms of the rules of the scheme and the Medical Schemes Act) are protected at all times. Members of medical schemes have to know that decisions relating to their scheme are based on the right reasons and not on external considerations. They have to know that no bias in decision-making exists and that decisions are based on facts, which facts have to be considered in relation to the specific legal frameworks within which the scheme operates.

Mere disclosure of a conflict of interest is therefore not sufficient to comply with the requirement that a trustee and Principal Officer not be conflicted. The Act stipulates that conflicts should be "avoided".

Gifts etc.

One form of possible conflict of interest is that of gifts, inducements, considerations and/or payments. According to Section 57(8) of the Medical Schemes Act, trustees must "disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the medical scheme".

The proposed corporate governance guidelines issued by the CMS in 2008 suggest that, as far as gifts, payments and considerations are concerned, disclosure would be required not only of the fact that such were received, but also of the:

- identity of the source of the gift, payment or consideration;
- reason for the gift, payment or consideration;
- date on which the gift, payment or consideration was given; and
- quantum of money or value of the gift, payment or consideration.

As far as gifts and sponsorships are concerned, trustees should develop policy guidelines to which Board members and the Principal Officer as well as key administrative staff should adhere. Policies should be clear on whether the gift or sponsorship may be accepted or not; a mere declaration should not be enough.

Penalties, liability and enforcement

The Registrar of Medical Schemes may, on the basis of Section 61 of the Medical Schemes Act, declare a particular business practice undesirable.

Non-compliance with the provisions of the Medical Schemes Act may have severe consequences. In *Watson and another v Shaw and others* the court found that the trustee responsible for the illegal conduct was personally liable for the damages of the scheme resulting from the breach of his fiduciary duty. The fact that the trustee was unaware of the illegality of his conduct was irrelevant and a claim for general enrichment was successfully brought before the court.

Other repercussions of non-compliance can include trustees being removed from office in terms of Section 46 of the Medical Schemes Act and even criminal liability in terms of Section 16(b) in cases of criminal conduct.

Other frameworks

Section 57(4)(h) of the Medical Schemes Act requires trustees to ensure compliance not only with the Medical Schemes Act, but also with "all other applicable laws".

The common law principles of administrative

Top 5 duties of trustees in terms of the Medical Schemes Act

- 1 Provide adequate and appropriate information to members.
- 2 Obtain expert advice.
- 3 Ensure compliance with the Act and all other applicable laws.
- 4 Act with due care, diligence, skill and good faith.
- 5 Avoid conflicts of interest.

Some laws that should form part of the regular legal compliance assessment/audit to be undertaken by Boards of Trustees

Law	Example of possible implications
Health professionals legislation (Health Professions Act, Nursing Act, Pharmacy Act etc. and regulations)	Requirements set for healthcare professionals by schemes should consider the legal and ethical framework applicable to such professionals, e.g. rules relating to clinical appropriateness of care
National Health Act and regulations	Provisions relating to informed consent by patients (beneficiaries), confidentiality and disclosure of information; also applies to health establishments, health research etc.
Medicines and Related Substances Act and regulations	Provisions relating to generic substitution; setting of formulas based on indications for which a medicine is registered
Constitution of the Republic of South Africa	Medical schemes provide beneficiaries with access to healthcare, but within certain limits; schemes may be challenged constitutionally as to the justifiability of the limits imposed
Administrative justice	Applicable to dispute committees and all decisions that affect the rights and interests of others
Labour legislation	Schemes employ staff
BBBEE Act and Codes	Illustrate that the scheme and its contractors are committed to Broad-Based Black Economic Empowerment
Consumer Protection Act of 2008	Ensuring that beneficiaries, being consumers of healthcare services, are even better protected

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The risk that every scheme faces

South Africa needs a system of risk adjustment for its medical schemes industry. Here are the most compelling reasons why.

By **Mondi Govuzela**
(RESEARCH ANALYST)

Membership of medical schemes is voluntary. Schemes are owned by their members and governed by Boards of Trustees of which at least half must be elected from among members of the scheme. Medical schemes are governed by the Medical Schemes Act 131 of 1998.

The latest audited figures show that there were 110 medical schemes at the end of 2009 and a large number of fragmented benefit options within each scheme serving a population of 8.1 million beneficiaries (meaning principal members and their dependants). This fragmentation in risk pools is responsible for the limited cross-subsidisation in the private health-care system.

Most medical schemes have fewer than 6 000 beneficiaries. This further limits the effectiveness of risk-pooling.

In the years before the end of apartheid, government introduced reforms that led to the abolition of prescribed minimum benefits and the freedom to use risk-rating by age and health status. These changes undermined the principle of cross-subsidisation between the healthy and the ill, the young and the old.

There has been a substantial return to solidarity principles since the advent of democracy in 1994. The new Medical Schemes Act of 1998 re-introduced the principles of open enrolment, community rating and prescribed minimum benefits (PMBs). These legislative changes were aimed at enhancing the risk-pooling function of medical schemes.

The open enrolment provision of the Medical Schemes Act compels open schemes (where membership is not linked to an employer, profession or union) to accept anyone who wants to be a member, and at standard rates. In terms of the principle of community rating, schemes must charge everyone the same standard rate, regardless of their age or health status. PMBs were introduced to ensure that all schemes offer a minimum package of health services. The law expects medical schemes to pay

for these benefits in full, without limits or co-payments. Membership of medical schemes continues to be voluntary.

In 2004 the Minister of Health announced that risk-related cross-subsidies, income-related cross-subsidies as well as mandatory cover for families with incomes above a certain level were missing pieces in the unfinished reform agenda towards implementing a system of mandatory health insurance. This policy trajectory has since been abandoned and government is currently exploring other ways to strategically reform the entire health system of South Africa.

Proposals that relate to changes in medical schemes include the introduction of a system of risk adjustment. Risk adjustment is a way of equalising the risk profiles of medical scheme members in order to avoid loading contributions on the insured to some preset extent. "This will effectively enforce community rating across all medical schemes so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join," Prof. Heather McLeod has said.

In its simplest form, full community rating will be achieved in a system of risk adjustment. The risk adjustment (or risk equalisation) fund will receive contributions from medical schemes with a younger age and better health profile, and pay amounts to medical schemes with an older age and poorer health profile. The fund could equalise the contribution tables of all medical schemes, preventing schemes from cherry-picking the younger and healthier lives and consequently eroding the balanced age and health profiles of other schemes.

The factors that have been tested to measure the risk profiles of medical schemes include age, maternity, numbers with each disease on the Chronic Diseases List (CDL), numbers with HIV/Aids on antiretroviral therapy, and numbers with multiple CDL diseases. The mechanism of

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The delay in the implementation of a risk adjustment system creates schemes with older and less healthy people and a higher community rate for the PMB package. This is neither fair nor equitable.”

risk-adjusted cross-subsidies can be instituted by means of a central risk adjustment fund.

The key objective of a risk adjustment fund in South Africa would be to protect the environment of open enrolment and community rating.

Medical schemes in South Africa have dissimilar risk profiles. Some have a high proportion of the chronically ill and elderly; others tend to attract members with lower risks. Some schemes appear to allocate a disproportionate amount of resources to their marketing activities aimed at attracting the young and healthy to become their beneficiaries.

Once risk adjustment is implemented, medical schemes will no longer be incentivised to compete on the basis of risk-selection but rather on the basis of cost-effective delivery of healthcare. Schemes which are successful at reducing the cost

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There has been a substantial return to solidarity principles since the advent of democracy in 1994.”

of delivery will retain that benefit for their members and will thus be able to lower their contributions for the prescribed minimum benefits. Schemes which are not successful at lowering delivery costs to the industry community rate determined by the risk adjustment fund would need to charge their members for the difference on a community-rated basis.

The delay in the implementation of a system of risk adjustment means that medical schemes will continue to design and market themselves in such a way that they attract younger and healthier people. This creates schemes with older and less healthy people and a higher community rate for the PMB package. This is neither fair nor equitable.

Risk adjustment systems operate in countries such as Australia, Germany, the Netherlands, Belgium, Switzerland, Ireland and Colombia. ■

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justice apply to all cases involving the rights or interests of persons within an organisation such as a medical scheme which is subject to an internal regulatory framework (the scheme rules) and structures such as the Board of Trustees.

In short, these principles (called the "principles of natural justice") include the following, all of which are good practice guidelines to follow when decisions are made or strategies approved:

- Hear the other side.
- Make sure you have all the information.
- Listen carefully to what various parties are saying.
- Be fair. (Do not be biased in any way.)
- Exercise the powers awarded to you for the intended purpose.
- Ensure that the decision is reasonable.

A second law which might relate to the issue of gifts and entertainment outlined above is the Prevention and Combating of Corrupt Activities Act 12 of 2004. This Act states that it is a crime (corruption) if someone "accepts or agrees or offers to accept any gratification from any other

person, whether for the benefit of himself/herself or for the benefit of another person", with the objective of influencing another person to act in a manner that is illegal, dishonest, unauthorised, incomplete or biased, amongst others, and which conduct constitutes either abuse of a position of authority or a breach of trust.

Trustees are *par excellence* in positions of trust towards the members of the scheme and should therefore be wary of accepting anything which might be aimed at influencing their decisions.

Another element, although not law, is found in the principles contained in the King III Report on Corporate Governance. According to the Institute of Directors, King III applies to all entities, regardless of the manner and form of incorporation or establishment. It has therefore been drafted "on the basis that, if [it is] adhered to, any entity would have practised good governance".

King III recommends that all entities disclose which principles and/or practices they have decided not to apply, and explain why. It is felt that this level of disclosure allows stakeholders to comment on and challenge the board to improve the level of governance within an organisation. ■

When you need a kind ear

The Customer Care Centre at the Council for Medical Schemes receives an average of 3 500 calls each month – and our consultants listen to each call with a kind ear.

By **Gugulethu Blose**
(COMMUNICATIONS OFFICER)

Bessie Molomo (Manager)

Bessie has been the manager at the Customer Care Centre since 2009. She ensures the smooth running of the call centre, which falls within the newly created Stakeholder Relations Unit, by



making sure that the consultants assist the public to the best of their ability.

"I see the consultants as providers of relevant guidance, advisors and interpreters of the Medical Schemes Act," she told *CMS News*.

Bessie believes the Customer Care Centre environment is unique.

"We deal with people from different backgrounds and with different needs. A kind ear is a must-have."

Hailing from the village of e-Sheshegu in the Eastern Cape, Bessie describes herself as a grounded person who was raised by her grandmother to never fear challenges but to gracefully embrace them as learning opportunities.

The proud mother of two enjoys watching movies, cooking and hanging out with friends.

“**The centre is the glue that holds it all together.**”

Phumla Khanyile (Consultant)

Phumla describes herself as passionate about helping others. She joined the Customer Care Centre over a year ago; the move has given her a sense of purpose and achievement.

"The centre is the glue that holds it all together."

Phumla finds that her communications background helps a lot in her duties as a consultant. "I



am a communicator; my communications qualification and experience come in handy. But I have also learned that in this industry you also need strong customer relations skills and a fair knowledge of the Medical Schemes Act."

Phumla's sensitive and tolerant nature allows her to deal with the complexity and sensitivity of the complaints she receives. She is currently studying further to obtain her law degree and believes the experience gained from the call centre will be invaluable towards her degree.

This mother of two, from Umtata in the Eastern Cape, says her work day starts with talking and ends with much the same, so she takes her leisure time seriously. "At work I have become friends with a cup of tea but at home you will find me on the couch with the remote control in hand, watching movies."

Lillian Mathabe (Consultant)

Born and bred in Pretoria, Lillian has been with the Council for Medical Schemes since the very beginning. "I started here 10 years ago and I have seen the CMS grow from strength to strength."

Lillian describes her role at the call centre as ensuring that members and other stakeholders



who contact the CMS are assisted, whether they need advice or information. "I try to approach my job with open-mindedness and embracing each day with its challenges."

Lillian has been with the centre for a year but she is more than familiar with the queries and complaints that come through because she had been with the Complaints Adjudication Unit since 2000. "The knowledge I gained of the Medical Schemes Act while I was working at the Complaints Adjudication Unit has helped me make the transition to the centre."

Her main sources of relaxation are the time she spends travelling with her family and unwinding in a warm bath after work.

“**A kind ear is a must-have.**”

Susan Malakoane (Consultant)

Susan is the newest member of the centre, having joined the team at the beginning of March 2011. She is no newbie to the CMS though; she has



been with us for nine years, first as a receptionist and then moving to the Accreditation Unit as an Accreditation Analyst.

"The Customer Care Centre is a very informative unit that interacts with all the business units at the CMS. The daily interaction with all our stakeholders who depend on us for guidance, keeps us on our toes as we have to provide accurate information at all times."

Her listening skills and patience allow Susan to be compassionate and provide excellent customer service to the callers who come through.

Susan describes herself as down to earth. She hails from Naledi Extension in Soweto and comes from a big family of four sisters and four brothers, one of her brothers being her twin. Her ethos is to let people say what they will as long as she remains herself. ■

Continued from page 1

has resulted in the spawning of various entities similar to medical schemes that operate outside the ambit of the Medical Schemes Act and make promises they cannot keep, more often than not misleading the public into believing that they offer the same protection and non-discriminatory environment that can only be found in a medical scheme. Since the judgement was handed down, the Council for Medical Schemes has had to be more sensitive than ever to applying the definition and registering medical schemes.

In enforcing the Medical Schemes Act, the Council for Medical Schemes requires that all entities which offer the services as per the definition of the business of a medical scheme are registered as such. When we register a medical scheme, we must be satisfied that the scheme complies with the definition of the business of a medical scheme and that it affords the protections that are the cornerstones of the Medical Schemes Act, including open enrolment, community rating and the package of guaranteed minimum benefits. The entities which operate outside of this protective environment enshrined in legislation operate outside of the definition and bounds of our control. Unregistered "medical schemes" are not allowed to perform the functions of a medical scheme.

The Guardrisk judgement has created a situation which poses numerous problems for the integrity of the health insurance industry in our country.

Inferior benefit packages are being provided by models alternative to the mainstream environment – and these packages do not include the PMB package prescribed by the Medical Schemes Act. But the nature of these new entities misleads many members of the public by offering a seemingly attractive package of healthcare benefits. Too often you find out too late that inadequate protection is provided for catastrophic health events that are outside of your control. The comprehensive cover for persons suffering from chronic ailments, for instance, as provided for in the PMB package, is not provided by these entities as they remain

unregulated. Members of the public are currently exposed to being abused by unscrupulous vendors with a profit-driven incentive; they are unfairly treated where they are deliberately misinformed and end up buying inferior health products with limited health cover.

Further, these new "medical scheme-like" entities apply risk factors to premiums that are related to your age and/or pre-existing medical conditions; this is unfair and results in these products becoming too expensive for older and sicker members to afford. They also undermine the benefit of risk-pooling and jeopardise the risk cross-subsidisation between the old and young, the sick and healthy. All this has an impact on the ability of medical schemes to provide cost-effective and efficient healthcare services and affects the long-term sustainability of the industry.

If the current trend continues, it could mean the end of the medical schemes industry as we know it.

The business of a medical scheme – the way forward

The Council for Medical Schemes is party to a comprehensive review process of the Medical Schemes Act to address this issue and others where gaps have been identified. Once the Medical Schemes Amendment Bill finally goes to Parliament, it is expected to address the demarcation issue to a large extent. We want it to be clear: the business of a medical scheme is to protect members of medical schemes against catastrophic financial loss due to illness; it is also to provide quality care.

While a legislative solution is sought, revised and improved definitions for PMBs are being developed and the multilateral pricing commission continues to encourage greater cooperation and negotiation efforts between medical schemes and healthcare service providers; these measures aim to introduce greater stability and sustainability across the entire medical schemes industry.

This delicate industry should be protected by law for the benefit of all South Africans. ■

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The delicate medical schemes industry should be protected by law for the benefit of all South Africans.”

Reception

t: 012 431 0500
f: 012 430 7644

Customer Care Centre (hotline)

t: 0861 123 CMS (267)
e: information@medicalschemes.com

Resource Centre

t: 012 431 0530
f: 012 430 7644

Use our website to:

- See whether your medical scheme is registered.
- Check if your healthcare broker is accredited.
- View lists of accredited administrators and managed care organisations.
- Find information relevant to the medical schemes industry, including forms, discussion documents and the Medical Schemes Act.

Complaints

t: 0861 123 CMS (267)
f: 012 431 0560 or 012 430 7644
e: complaints@medicalschemes.com

How to resolve disputes

- Speak with your medical scheme first. All schemes are required by law to establish dispute resolution committees. Give full details of your complaint and include any supporting documents.
- If you are not satisfied with the outcome of your complaint to the scheme, lodge a written complaint to the Registrar of Medical Schemes at the Council for Medical Schemes.
- If you are aggrieved by the decision of the Registrar, appeal his/her decision to the independent Appeals Committee of the Council.
- If you are aggrieved by the decision of the Appeals Committee, appeal to the independent Appeal Board.

How to avoid disputes

- Understand the rules of your medical scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option you have chosen.
- Pay your contributions in full and on time every month.

This newsletter is printed on environmentally friendly paper.

Reading matter
Between 1 April 2010 and 31 March 2011, we continued to publish various documents on our website, including:

- Our Annual Report 2009-2010
- Quarterly reports on the performance of medical schemes
- 67 Circulars
- 20 press releases
- 9 issues of CMScript, our e-newsletter on prescribed minimum benefits
- 12 documents on prescribed minimum benefits
- 15 documents on Acts and Regulations
- 13 guidelines and manuals
- 29 judgements on appeals
- 4 documents for administrators
- 4 documents for managed care organisations
- 4 documents for brokers
- 7 application forms

Visit www.medicalschemes.com for more.



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