

# Knowing your way around Medical Schemes issues

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## SPECIAL POINTS OF INTEREST:

- How to choose a medical scheme
- What all medical schemes have to pay for
- Who runs and owns medical schemes
- What it means if a scheme selects a DSP
- Explanations and definitions of words used in the medical scheme environment
- "Closed" and "open" schemes
- Abbreviations

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## What are medical schemes?

Because very few people can afford the costs of healthcare out of pocket, medical schemes provide a way for people to pool resources in order to cover these costs. Together we can afford more than as individuals.

In a sense, it works very much like the traditional African "stokvel" or "oorgooi". The biggest difference is that it is one's turn to access money from this pool only when one needs healthcare, such as when a member falls ill or if someone has been in an accident. As in a stokvel, a medical scheme also has **rules** as to who can get money from

that pot, when they can get it, how much they will get, etc. This "pot" of money is called



Medical Schemes work on the principles of community risk and solidarity.

the "**risk pool**" of the scheme. Medical schemes are compelled by law to fund certain illnesses and events from this risk pool (see discussion on prescribed

minimum benefits - PMBs). Generally, having healthcare funded collectively benefits society at large. The young fund the old, and the healthy fund the sick. But if you fall ill, you will also benefit from the risk pool.

Medical schemes are **different from other insurance** such as life, disability or funeral cover. In such cover they work with your individual risk profile. For example, if you have high blood pressure you are likely to pay a higher monthly premium or contribution. A medical scheme cannot ask a higher premium on your health status, but they may impose limitations on reimbursement, depending on the option purchased by you.

## Controlling a medical scheme

Medical Schemes belong to their members. They are not-for-profit organisations. If they do have money left over at the end of a year that money has to be used to the benefit of the members of the Scheme. They also have to keep part of that money as reserves.

A medical scheme is run by a Board of Trustees (BoT). Half of the trustees must be directly elected by the members of the scheme, the rest is appointed by the scheme. The BoT has to appoint a Principal Officer, who acts as the manager of the scheme.

### Tip for medical scheme members:

Find out who the trustees and principal officer of your medical scheme are and their contact details.

It is the duty of the Trustees to:

1. Look after the welfare of the scheme and its total membership.
2. Ensure that the scheme complies with the law.
3. Make sure that accurate information is provided to members on their rights, responsibilities, benefits and contributions.
4. Obtain expert advice on issues where they have no expertise. For example, should a decision be made not to fund a certain illness anymore, expert health professional advice (apart from the financial and business advice) should be obtained as to what the impact of this discontinuation will be on health of the members and on the future financial position of the scheme.

Trustees must make decisions in the interests of the members of the

scheme and may be held personally liable for the consequences of the decisions they make. Members should also get involved with their schemes at the Annual General Meeting of the scheme.

Some schemes appoint administration companies to run their affairs. They may also have contracts in place with managed care organizations to oversee the types of treatments and the cost thereof. Data companies may also be involved as they provide the software for claims transfers. Note that these companies / organisations can make a profit. If a medical scheme member has a problem, that problem may originate at administrator-, scheme-, managed care-, or data company level. However the trustees and the principal officer remain responsible towards the members, and must be able to assist in dealing with problems arising in such cases.

# Joining or changing medical schemes

“When changing medical schemes, be sure to resign from the one and join the other scheme within **three months**”

“No limitations may be placed on the reimbursement of the PMBs if one changes schemes within 3 months and was a member for at least 2 years before changing”

Even if you have never belonged to a medical scheme, you can join one. You can also change from one scheme to another.

However, the law states that the scheme may determine that they will not, for a certain period of time, fund certain illnesses, although you will belong to the scheme for that period. Schemes may also charge late joiner penalties

if you were never a member of a medical scheme. Ask the scheme you want to join about these periods and penalties before joining or changing schemes.

The table below gives a good idea of what **waiting periods** may apply, during which you will have to fund the treatment of such conditions yourself.

Situation:	Waiting period	
	General -	Condition-specific -
I have not been a scheme member for 3 months before joining a (new) scheme	3 months	12 months
I was a member of a scheme for 2 years and have joined a new scheme within 3 months of leaving the other scheme.	None.	Maximum 12 months, but they have to fund the PMBs (see next page)
I have changed my benefit option	None, unless member is subject to a waiting period under previous option, then remaining period may be applied	
My child was born during my membership of a scheme	No waiting periods may be applied to such child	
I changed jobs and had to join a new scheme or I am not employed anymore where I previously had medical scheme cover.	None, but if there is still a waiting period running from the previous scheme, the new scheme may continue by applying the unexpired period.	



Information on the financial security and the level of benefits of various medical schemes can be obtained from the Council for Medical Schemes and reliable brokers. Remember to consider your potential health needs in conjunction with your healthcare professional.

## Checklist of issues to consider when choosing a medical scheme

1. Is the scheme financially secure?
2. What is the scheme's claims ratio, i.e. how much of every rand is spent on healthcare, and how much on non-healthcare, such as administration, commission, managed care, etc?
3. What benefits does the scheme offer and at what cost?
4. What are your and your family's healthcare needs? Are there familial diseases that may affect the family in future?
5. Do the benefits cater for current & future needs?
6. Have limitations been placed on the amounts that you may claim for, for example, acute medicine, hospitalization or specific treatments (e.g. cancer or heart disease)?
7. At what rate ("private", scheme (medical aid) rates or real cost) does the scheme reimburse healthcare costs? This may mean you have to co-pay if costs charged by a healthcare provider and the benefits of the scheme option are not the same.
8. Are there restrictions on the doctors, hospitals and pharmacies you may visit? Are these convenient to you?
9. Does the scheme use a formulary (medicine list)? Does the list include medicines used, or likely to be used by you and your family? Does the scheme totally exclude certain medicines?
10. Does the scheme provide value for money considering your budget and health needs?
11. How much of the monthly contribution goes towards the general risk pool and how much are savings?
12. Does the scheme measure health outcomes and quality of care? Do they report on how much "better" their members' health are?

# PMBs: Your most basic rights in medical schemes

All medical schemes must, on all benefit options fund in full the diagnosis, treatment and care costs of more than 270 conditions, called the Prescribed Minimum Benefits (PMBs). Also included in the list of treatments that have to be funded are 25 chronic conditions – also called the chronic disease list or CDL (see below), all emergency treatments and HIV treatment according to national guidelines. The PMBs describe the minimum that schemes must fund. It is not the maximum of what a scheme

must fund. Nothing in the law prevents a scheme from funding any condition to a greater extent than described in the law. This is why the PMBs are called a minimum “safety-net” for patients.

One can never run out of funds for the treatment of the PMBs, no matter how often it happens. Costs that must be covered include medicine, reasonable tests to confirm the condition or disease, and all costs associated with the descriptions of the treatment as set out in the law.

The PMB list, for example, states

that if a patient has a cleft palate (diagnosis), the scheme must fund the repair thereof (treatment). Payment in full means that the scheme cannot impose co-payments for PMBs. Many PMB conditions may require hospitalisation, but it does not mean that a patient must always be hospitalized for the PMBs, unless the designated service provider (DSP) is a hospital. Schemes must, at a minimum, fund a PMB condition the same as treatment that would have been given in the government hospitals and clinics.

**“All medical schemes must cover in full the diagnosis, treatment and care costs of the PMBs” (regulation 8)**

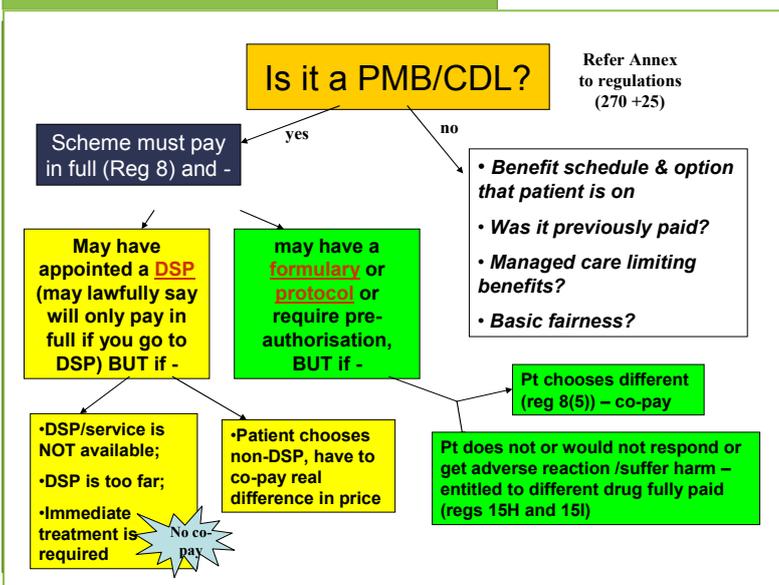
## Balancing cost & care ...

No medical scheme could afford to fund the PMBs without any limitations. The law provides two options to schemes to ensure that the costs associated with the PMBs are manageable. Schemes can:

- Appoint designated service providers (DSPs) and/or
- Have formularies & treatment protocols and only fund diagnostic, treatment and care costs that fall within those formularies and treatment protocols.

However, where patients exercise a free choice that does not form part of the scheme's DSP's, formularies or protocols, the scheme can ask for a reasonable co-payment.

Where the patient has no choice, such as where there is no DSP available, or where the patient is not getting better on the formulary medicine, the scheme must pay for an alternative and may not charge a co-payment. If the treatment is for a condition that is not on the PMB list, the requirements that an appropriate alternative must be paid for where the treatment did not work, or the patient experienced bad side effects, still apply.



## What are part of the PMBs and what are not?

There are three “types” of PMBs:

- The Chronic Disease List (CDL)
- The 270 treatment and diagnosis pairs
- Emergencies

The CDL includes 25 conditions for which patients would require continuous medication and treatment. Most common are hypertension, diabetes, asthma, epilepsy, rheumatoid arthritis, hyperlipidaemia (high

cholesterol), cardiomyopathy (inflammation of the heart muscles), cardiac failure, chronic renal disease, Parkinson's, HIV (anti-retroviral treatment), etc.

Emergencies are defined by the law as all sudden and unexpected conditions that require immediate medical or surgical treatment, without which the patient faces a loss of life or limb or serious bodily harm. All emergencies must be covered by medical schemes.

The 270 pairs include, amongst others, various treatable cancers, gastroenteritis, hormone replacement therapy, infertility treatment, attempted suicide, sexual abuse, hip fractures, non-life threatening open wounds, etc.

Some conditions that do not form part of the PMBs include osteoporosis, chronic depression (i.e. depression for more than 6 weeks), contraception and acute conditions such as flu.

Members who belong to “higher” options should enquire as to the depth of funding for PMBs (e.g. to what extent is depression or cancer covered). Members have to know how far the cover of various diseases will go and if the funding goes beyond the minimum levels prescribed.

Members also have to know if any “additional” conditions, such as osteoporosis, etc. that are not on the list, are covered or not.

# Designated Service Providers & PMBs



*Beneficiaries of medical schemes who obtain health services from their schemes' DSPs may not be required to make any co-payments*

*According to the Council for Medical Schemes, co-payments for PMBs may never be paid out of a patient's savings account.*

No limitations, co-payments or other restrictions may be placed when a beneficiary obtains services for a PMB from a DSP. This means that if hospital ABC is selected as a DSP, and your child has pneumonia (a PMB), the scheme must pay in full for if you take your child to hospital ABC for the treatment of her pneumonia. If, however, you chose another hospital, you might have to pay the difference in cost between hospital ABC and the hospital you chose.

Sometimes it may not be possible to use the scheme's DSP. In such cases the scheme still has to pay in full, and **cannot ask for a co-payment..** These cases ("involuntary use") are -

- **The DSP or the service required is not avail-**

**able.** For example, x-rays are required and the facility does not provide such services, or the specific service is fully booked and it is not advisable to delay obtaining the service.

- **Immediate services are required.** For example, where a dependant breaks an arm during the family's vacation at a small sea-side development and is taken to the GP in the nearest town, who is not a DSP.
- **Where the DSP is too far from the beneficiary's home or work.** For example, the member can only visit the doctor after work, but the DSP is closed by the time s/he gets there. Then the scheme has to pay, without co-payment, for the member

to visit a non-DSP doctor close to their workplace after working hours or perhaps during his or her lunch.

For conditions that are not PMBs (such as flu or fever), members can go to any provider of choice.

## TIP FOR MEDICAL SCHEME MEMBERS

Find out who the DSPs are that your scheme has selected. Also find out for which PMB conditions you have to go to them (e.g. for mental health or for all PMBs or for hospitalisation you have to go to, e.g. Drs XYZ and/or hospital ABC).

If the DSPs are inaccessible or unavailable, bring this to the attention of your scheme's Principal Officer.

## Pre-authorization



Medical schemes may require pre-authorization before they

fully fund the diagnosis, treatment and care costs of the PMBs. Schemes use this mechanism -

- To establish whether a condition is indeed a PMB (i.e. they confirm the diagnosis);
- To establish/verify whether a DSP is indeed unavailable;
- To establish what the extent of the treatment, and hence, the associated cost will be.

However, pre-authorization may not be used to avoid funding any of the PMBs.

Medical scheme members often require the assistance of a healthcare professional to fill out pre-authorization forms, particularly where they require treatment that differs from that generally paid for by the scheme.

## Government hospitals and clinics as DSPs

The law allows schemes to select a DSP and some select the public sector (i.e. state hospitals and clinics) as their DSPs.

Members of medical schemes are entitled to know when their scheme select DSPs, who these DSPs are and where the DSPs are situated. This means that members have to be notified of these aspects.

Members should know when they should go to the public

sector, if this is their DSP. Members do not want to be caught off guard in going to the "wrong" facility and for example having to switch to another facility at some stage.

No limitation may be placed on reimbursement for services obtained in the public sector, i.e. if a member goes to a government hospital or government clinic for a PMB, the full bill must be paid by the scheme.

# Managed care: What it is, and how does it work?

Managed care refers to a number of strategies that can be used by medical schemes to manage the costs associated with healthcare services and treatment. For example:

- Using set treatment plans (algorithms) and medicine lists (formularies).
- Using case managers to help to determine the best care options for a particular patient in a particular setting.
- Using designated service providers (DSP's) or preferred providers.

Patients should ask their healthcare service providers whether they form part of managed care agreements with their schemes, as it may influence treatment options and costs.

Various provisions in the law and policy statements protect patients and providers in the application of managed care. These rules include that -

- Managed care is not only about costs, but also what is appropriate for the specific patient's healthcare needs.
- Patients are entitled to know what limitations are being placed on their healthcare.
- Patients who do not respond on the treatment recommended by managed care systems, are entitled to appropriate alternatives.
- Healthcare professionals have to oversee the implementation

of the managed care programme.

- All involved with managed care, i.e. doctor groups, hospitals, pharmacy chains, medical schemes, managed care organizations, administrators, etc had, by 1 January 2004, to register at the Council for Medical Schemes before they could implement and/or practice managed care.
- Healthcare professionals who have agreed to function under a managed care programme still have to be able to recommend to patients the appropriate care, and not blindly follow the managed care rules.

Useful guidelines on how managed care should be implemented:

- Council for Medical Schemes *Managed Healthcare Policy of 2003* (available at [www.medicalschemes.com](http://www.medicalschemes.com) under "Guidelines and Manuals") - policy applicable to medical schemes.
- Health Professions Council of South Africa *Undesirable Businesses Practice Policy of 2003* (available at [www.hpcs.co.za](http://www.hpcs.co.za)) - policy applicable to doctors, physiotherapists, dentists, etc.



## Managed care: Medicines and Formularies

The management of medicines cost is a key managed care strategy.

Schemes may have a formulary (i.e. a list of medicine they will pay for). Some schemes also have medicines exclusion lists in place, i.e. a list of medication they will not pay for at all. In other cases, limits are placed on the total cost of medicines that will be funded for certain types of illnesses. For example, acute medicine (i.e. medicine for day-to-day health needs that may occur such as flu or ointment for an eye infection), will be paid for, but only up to a limited amount of Rx.

When at a pharmacy, patients should bear the following in mind:

1. If the medicine is not paid for, patients should ask what the reason for this is. Medicines for PMB treatments on all options

have to be funded in full, unless the scheme has a formulary in which case they will only pay for the medicine on the list / formulary.

2. The doctor should discuss various treatment options with a patient. The patient may then decide to opt for a medicine that is not on the formulary. If the patient would have done fine on the formulary medicine, the scheme must pay the amount that it would have paid for the medicine on the list. The patient has to co-pay approximately the difference in price between the list-medicine and the medicine of choice.

3. If a certain medicine on the list did not work for a patient, the patient is entitled to another medicine that may have a greater chance to work, even if such other medicine is not on the formulary / list. The same applies when the medicine on the list caused the patient to feel unwell.

4. Sometimes patients find at a pharmacy level that the medicine that was prescribed is not paid for by the scheme. The pharmacist then sometimes offer the patient an alternative medicine. In terms of the law, this alternative medicine must be a real

generic version of the original that the doctor prescribed. Generic products have the same active ingredients as the original medicine. A patient may decline generic substitution. Accepting or declining generic substitution must be noted on the prescription.

If the change proposed by the pharmacist is therapeutic (i.e. the medicine has different active ingredients) the doctor of the patient has to confirm that this switch is indeed in order. The doctor will then have to issue a new prescription.

If a patient declines generic substitution, the medical scheme is likely not to pay directly and patients can be asked to pay the full amount out of pocket. However if the medicine was for a PMB, the patient is entitled to have the value of the medicine on the list paid for. The patient would then only be liable for the price difference.

Most software used in pharmacies have functions to cater for the situations discussed above, such as co-payments, or for the alternative medicine to be authorized on-line. If not, the scheme trustees may authorize the software house to activate these features on the system.

## THE CMS ANNUAL REPORT:

### Getting a pulse on medical scheme health - membership



How many people belong to medical schemes? How does this membership look? What do medical schemes pay out, and to whom? We will attempt to address these and related questions in the next two pages, using the Council for Medical Schemes' 2004-2005 Annual Report as our source.

The Council for Medical Schemes Annual Reports set out the financial status of the various schemes, the status of the sector as a whole, as well as set examples of successful complaints against schemes.

"Problems with medical schemes may, after addressing it with the scheme, be brought to the Council for Medical Schemes"

#### Medical scheme membership: Opportunities for growth and better cover in South Africa

The greater the pool of risk contributions, the easier to manage cost and the health-care needs of the population. However, medical scheme membership has remained stagnant over the past few years, covering just under 7 million beneficiaries. Of this number, some 2,8 million people are principal members, and the rest are dependents. Just as stokvels work best when more people contribute, medical schemes work best if there are as many contributors as possible (but remember, not everybody demands their turn every month!). It also works well if there is a good mix of young and healthy contributors, not claiming, and older or sick contributors who need funding. If this cycle is maintained,

there would be a constant supply of new young and healthy members contributing to the system.

Current medical scheme membership indicates that the age group 20 - 29 does not belong to medical schemes as much as older and younger age groups. The government is working on policies to address this, such as the envisaged schemes for low-income earners, the new government employee medical scheme (GEMS) and tax reforms on medical scheme contributions.

South Africa has 133 registered medical schemes, of which 48 are "open" schemes and 85 "restricted" or "closed" schemes. Closed schemes can only take on

members who belong to a certain (group of) employers, whilst the membership of open schemes are open to all people. 114 of the medical schemes use managed care tools to reduce cost.

Medical schemes have to admit all applicants, irrespective of the person's health status, age or gender. They may, however, charge a higher contribution on the basis of income and/or number of dependents. Unlike "ordinary" insurance, they may not "load" premiums on the basis of past or present health status.

Where schemes face a higher than average risk, for example when they have many pensioners as members, a Risk Equalisation Fund (REF) will pay fixed amounts to such schemes to assist them in averaging out their risk when compared to schemes with younger and healthier members.

#### Tip for medical scheme members

The Council for Medical Schemes (CMS) oversees the affairs of all medical schemes. If you have a problem at your medical scheme, you have to take the following steps:

1. Write down the issue clearly. Attach copies of documents, for example, unpaid accounts, prescriptions, etc. Refer in your letter to these documents and the dates when and places where (e.g. specific doctor or hospital) the issues arose. Keep copies of all of these documents for yourself.
2. Take the issue up with the medical scheme, or its administrator. Make sure

that you document and keep details of who you spoke with, who you were referred to, what their responses were, etc.

3. If you are not satisfied, contact the Principal Officer or a Trustee of the scheme.
4. If you are still not satisfied, you may complain at the Council for Medical Schemes.
5. The last port of call is the Appeals Committee at the CMS.

#### CMS CONTACT DETAILS

Share call: 0861 123 267  
Tel (012) 431 0500; Fax (012) 430 7644  
Private Bag X34 Hatfield 0028

## THE CMS ANNUAL REPORT (continued):

### Getting a pulse on medical scheme health - claims pay-outs

Members need to understand what portion of their contributions go to what type of healthcare costs and whether they will have the benefit of risk pooling or not. Sometimes schemes also offer threshold benefits or “top-up” contributions, and extra day-to-day benefit cover (over and above the PMBs). If members move to a higher option to obtain better day-to-day benefits, they should also ensure that the other benefits, such as hospitalisation and major medical cover is giving the same or better value.

Members of schemes have to be aware of both the “risk pool” and the “savings account” or “day-to-day cover” of schemes. As stated elsewhere, the risk pool is the general “communal pool” of benefits, whilst the savings accounts effectively is only a particular member’s portion of contributions that are put aside for that member and his or her dependants.

	Risk Pool (mostly PMBs)	Savings (non-PMBs)	Of total benefits paid
GPs	5,9%	15,5%	7%
Medicines	17,3%	34%	19,2%
Total Hospitals	42,6%	1,5%	38%
Specialists	19,9%	19,3%	19,9%

The Registrar of the Council for Medical Schemes has expressed concern about the payment of benefits from savings accounts in 2004. For example, costs of going to a GP and costs for medicines are paid to a greater extent out of a patient’s savings account, i.e. comes directly from the individual’s contributions. This means that patients may not be benefiting from risk pooling as far as portions of GP- and medicines costs, for example, are concerned.

#### Tip for medical scheme members

- Prospective and current medical scheme members should ask what exactly (a) the various types of contributions (“savings”, “top-ups” etc) and (b) various benefit levels (funding- “in full”, - at “NRPL-rates”, - at “private rates”, etc.) mean.
- When deciding on benefit options or medical schemes, people have to consider: their health needs and priorities and what part of their premium/contribution go towards the various pools and what costs are funded from such pools.

### Is my scheme paying for more or less than other schemes?

This section shows the importance for medical scheme members to establish, in general, whether their scheme is performing better, or worse, than the average other scheme.

Members can look at the pay-outs of their own schemes and compare it to the average. Members can then also, from one year to another, see how their scheme is paying out for various types of health services.

Let’s say one notices that the scheme pays out less than the average for GP’s. Does this mean that fewer members went to GP’s? Or does it mean that the number of GP visits that members could have, has been limited? Or did the scheme get a better deal from a GP group at lower cost? Did this actually benefit the members?

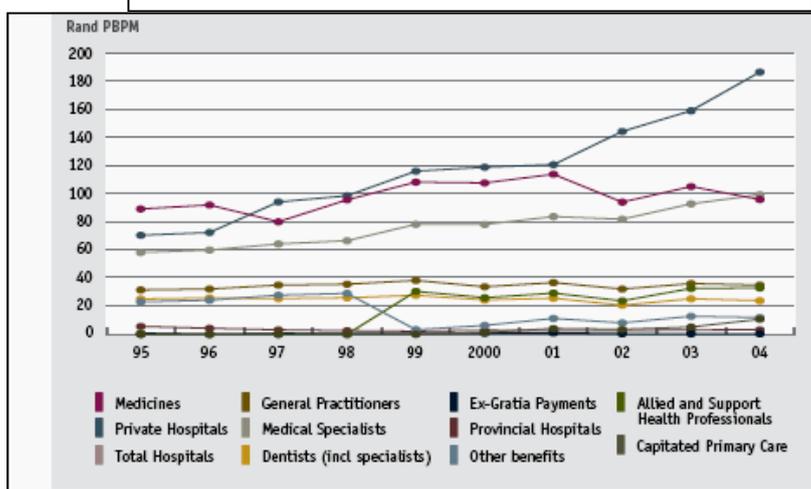
The most pertinent average amounts paid per beneficiary per month (PBPM) across all scheme options in 2004 were as follows:

- Hospitals: R189,70 (as compared to R162,10 in 2003).
- GPs: R35 PBPM (as compared to 2003’s R36,10). This means that schemes on average paid out less towards GP’s in 2004.

- Medicines: R95,90 in 2004 (as compared to 2003’s R105,20). Further decreases are expected when the pricing regulations are implemented in full.

Medical scheme members also has to look at a scheme’s claims ratio. This is a % that gives a member an idea how much of their premiums are spend on health, and how much on non-health costs. The average for all schemes is 78,6%. A lower percentage means that a scheme is more expensive and has paid more on administration and other non-healthcare costs than other schemes had.

Average benefit paid per beneficiary per month, 1995- 2004:



# IMPORTANT WORDS AND PHRASES

**Administrator:** A business that manage the day-to-day affairs of a medical scheme, i.e. evaluate and pay out claims, manage membership (queries, etc) and new members, advise the scheme on cost management and clinical issues, etc. Some schemes self-administer, i.e. they do not contract another company to do that for them and the scheme itself employs people to fulfill these functions.

**Beneficiaries, members, dependants:** *Members* of medical schemes are persons who belong to that scheme and who pay their contributions as required by the scheme. Members may register *dependants* on the schemes according to the scheme rules. Members and dependants are both called *beneficiaries* of the scheme.

**Council for Medical Schemes (CMS):** The body established in terms of the Medical Schemes Act (law) to oversee the affairs of medical schemes. Also the ultimate complaints body for medical scheme members.

**Designated Service Providers (DSP's):** Providers (doctors, hospitals, health facilities, pharmacies, etc.) selected by a scheme to provide health services to it's members. Members have to be informed of who their DSPs are. DSPs should be accessible.

**Formularies:** Medicine lists used by medical schemes, managed care organizations and administrators to control costs associated with medicines. Some schemes also have medicines exclusion lists, i.e. medicines that, if claimed, the scheme is likely to decline to pay for. Special motivations are often required in order to have such medicines, or off-formulary medicines reimbursed.

**Generic substitution:** Switching a prescribed medicine with a generic equivalent, i.e. a medicine made as an exact copy of the original product, i.e. with the exact same active ingredients. The law stipulates that patients have to be informed of generic substitution and may consent or refuse to consent to such switches. Generic substitution does not have to be confirmed with the doctor who prescribed the original medicine.

**Managed care:** Strategies used to balance the healthcare requirements– and cost aspects of the beneficiaries. Include aspects such as formularies, protocols, pre-authorization, utilisation reviews, capita-

tion, etc. Schemes themselves, provider groups or special managed care organization can fulfill this role.

**Medical scheme:** An organization, registered at the CMS to provide for– and manage the healthcare needs of its beneficiaries, to obtain contributions from members, on a not-for-profit basis. Medical schemes may register more than one option that provides different types of benefits at different rates of contributions.

**Protocols/Algorithms:** Guidelines set for the way in which certain health conditions are to be diagnosed and treated. Often contains options if one proposed method of treatment does not work, what should be done secondly, thirdly, etc.

**Prescribed Minimum Benefits (PMBs):** The minimum set of conditions that all medical schemes on all options must fund, to the extent described in the law.

**Principal Officer (PO):** The most important official in a medical scheme, responsible for seeing that the scheme's operations run smoothly. Reports to Board of Trustees.

**Risk pool:** The big pool of shared resources, comprising all contributions, from which, at least, all the PMBs must be funded for all members of an option or scheme.

**Savings Account:** Part of a member's contribution that is held separately from the risk pool and from which certain benefits, often day-to-day healthcare costs, are funded.

**Switching/clearing/data houses:** Organizations that develop and sell the electronic software for claims processing used by schemes and providers.

**Therapeutic substitution:** Switching a medicine with another that has a similar action. Medicines do not have exactly the same active ingredients. Not permitted without the consent of the doctor who prescribed the original medicine.

**Trustees:** Persons appointed by the scheme and its members to take ultimate responsibility for the running of the scheme in the interests of all its members. Trustees are liable for the decisions they make. They have to balance financial security with health needs in their scheme

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**It does not constitute legal opinion and readers are advised to consult with experts in all cases that may arise in the context of the information provided.**

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PO Box 2008, Houghton 2041  
Tel: +27-11-880-4644  
Fax: +27-11-880-5987  
info@imsa.org.za / www.imsa.org.za

