Prescribed Minimum Benefits complaints: A 5-year retrospective review

L M Ngobeni,[1] MSc, MPH; **M L Moropeng,**[1] MSc; **E Thsehla,**[2] MSc, PhD

[1]*Schools of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria, South Africa*
[2]*SAMRC/Wits Centre for Health Economics and Decision Science, Wits School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

Corresponding author: *E Thsehla (thsehla.eve@gmail.com)*

Background. Medical schemes are required by the Medical Schemes Act No. 131 of 1998 to pay costs associated with the diagnosis, treatment, or care of a specified set of benefits known as Prescribed Minimum Benefits (PMBs). Medical scheme beneficiaries have the right to lodge complaints with the Council for Medical Schemes (CMS) when their claims are denied.
Objective. To determine and describe the pattern of PMB complaints received by the CMS from January 2014 to December 2018.
Methods. This was a cross-sectional study that utilised the CMS's clinical complaints database. Data for PMBs, complainants, medical scheme types, and reasons for payment denial were extracted. The CMS's lists of chronic conditions, PMBs, and registered schemes were used to confirm PMBs and to categorise schemes as either restricted (i.e. to members of specific organisations only) or open (i.e. to all South Africans). Extracted and coded data were analysed using SAS v.9.4 software.
Results. A total of 2 141 complaints were retrieved and 1 124 PMB complaints were included in the study. The median of PMB complaints per year was 225. Most of the complaints (43.6%, *n*=490/1 124) were lodged by members themselves. Non-communicable diseases constituted most of the PMB conditions that members complained about. Medicine and surgery were the services that were mostly denied full payment by medical schemes. Open medical schemes accounted for many (73.8%, *n*=830/1 124) of the complaints.
Conclusion. Chronic conditions are the main diseases that medical scheme members complain about. Member education and clear definitions of PMBs should be prioritised by medical schemes and the CMS.

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Medical aid schemes are not-for-profit organisations[1,2] that have a responsibility to provide health insurance coverage to members and their dependants.[3] Membership of a medical aid scheme ensures that beneficiaries' healthcare costs are covered, based on a predetermined benefit structure, through the payment of monthly contributions.[2,4] Medical schemes cover about 16% of the South African (SA) population.[5] In addition to medical schemes, medical aid scheme members also pay out-of-pocket expenses to access healthcare services from private service providers such as doctors and hospitals.[5] In 2018, there were 78 registered medical schemes in SA, of which 20 were open medical schemes and 58 were restricted medical schemes.[6] Open medical aid schemes are open to all South Africans above the age of 18, who can afford to pay the monthly contributions and are not members of any other medical aid scheme. Restricted medical aid schemes, on the other hand, are restricted to specific individuals such as employees of a particular organisation and their families.[1,2,4,5]

Despite the benefit option members have chosen, medical schemes are required by the Medical Schemes Act (MSA) No. 131 of 1998 to pay costs associated with the diagnosis, treatment, or care of a specified set of benefits known as Prescribed Minimum Benefits (PMBs).[7] PMBs are a list of minimum benefits that ensure that all medical scheme beneficiaries have access to certain health services. PMBs include any medical condition that meets the definition of an emergency, a limited set of 270 (271 since 2020) medical conditions, and 26 chronic conditions defined in the chronic disease list (CDL).[7] PMB conditions qualify for coverage regardless of the cause of the condition. In addition, sequelae of certain conditions, as well as non-PMB conditions that are a direct result of PMB conditions, are covered as PMB conditions.[8]

The objective of specifying a set of PMBs was given in the 1999 Regulations as: [4,9]

1. 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.
2. To encourage improved efficiency in the allocation of private and public healthcare resources.

This means that regardless of whether the member's annual benefits have been depleted, the medical aid scheme should cover all expenses associated with any emergency medical condition, PMB condition, or CDL condition without co-payments or use of deductibles.[10]

The Council for Medical Schemes (CMS) was established through the MSA to provide regulatory supervision of medical schemes.[11] Members of medical schemes have a right to lodge a complaint with the CMS whenever health services have been wrongfully denied payment by their schemes.[4] One of the roles of the CMS is to ensure that complaints raised by scheme members are handled appropriately and speedily. To do that, the following process is undertaken:[12] (*i*) a member lodges a complaint to the legal adjudication unit, and it gets allocated to legal adjudication officers within the CMS's legal adjudication unit; (*ii*) a preliminary analysis is conducted, and the complaint is then classified as either an administrative, clinical, or legal/compliance complaint – clinical complaints are then sent to the clinical unit; (*iii*) the clinical unit analyses and investigates the complaint, and then provides a clinical opinion which is sent back to the legal adjudication unit; (*iv*) the legal adjudication unit then refers the complaint to the scheme in question for a response; (*v*) the registrar then makes the final decision based

on the evidence presented and the scheme's response; (*vi*) the complaint undergoes a final classification, and a response is sent back to the complainant.

Complaints from patients can be about a variety of issues related to scheme membership. In addition to resolving complainant issues, complaints can bring about change, address dissatisfaction, and prevent future problems.[13] Research suggests that a rise in healthcare complaints can be attributed to consumers' increased awareness of their rights in the healthcare system.[14] A dramatic increase from 291/3 138 (9.3%) in 2008 to 1 138/4 488 (25.4%) in the number of complaints about PMBs was noted by the CMS in 2009.[4,15] According to the CMS, most of the complaints were due to non-payment of PMBs by medical schemes. In 2009, a task team consisting of different stakeholders formulated a code of conduct to ensure complete compliance with the PMB provisions. This resulted in a decline in PMB complaints in 2009/2010.[4,15] Despite this intervention, PMB complaints increased to 2 370/5 963 (40%) by 2011/2012.[4]

This research determines the types of clinical complaints reviewed by the CMS's clinical unit and medical conditions related to complaints between 2014 and 2018 to identify trends in PMB-related complaints. The objectives were to determine and describe the pattern of PMB complaints received by the CMS from 1 January 2014 to 31 December 2018, and to identify medical conditions related to the clinical complaints reviewed by the CMS.

Methods

Study design and data collection

This was a descriptive cross-sectional study. The data were retrieved from the CMS clinical unit database. A total population sampling (TPS) approach was used, meaning that all clinical complaints from the database were evaluated. The data were stored in individual written complaints reports which were downloaded from the database. The collected data were entered into a Microsoft Excel (2016) (Microsoft, USA) sheet and coded. The following data were extracted: (*i*) the different types of complainants; (*ii*) the year the complaint was lodged; (*iii*) whether the condition was a PMB or not; (*iv*) the intervention related to the complaint; (*v*) the reason for payment denial; and (*vi*) the type of medical aid scheme (open or restricted). The CMS's lists of PMBs and the 26 chronic medical conditions confirmed whether the conditions were PMBs. The CMS's list of registered medical aid schemes was used to categorise medical schemes as either open or restricted.

Data analysis

Descriptive statistics (i.e. percentages and frequencies) were used to summarise categorical data while means were used for numerical data. SAS (version 9.4) software (SAS, USA) was used for analysis.

Ethical considerations

Permission to utilise the data was received from the CMS's chief executive officer and ethics approval was granted by the University of Pretoria's Faculty of Health Sciences Research Ethics Committee (ref. no. 628/2019).

Results

A total of 1 124 PMB-related complaints were included in the study. Complaints that did not meet the inclusion criteria were excluded (Fig. 1). Of the 1 124 beneficiaries who complained, 52.8% (*n*=594) were female and 47.2% (*n*=530) were male. The age of the beneficiaries involved in the complaints ranged from 1 day to 94 years, and the mean (standard deviation (SD)) age was 50.3 (18.7) years. Fig. 2 illustrates the distribution of complaints across gender and age per year. The ≥65 years age group had more complaints compared with the other age groups. Overall, open medical aid schemes accounted for 73.8% (*n*=830) of the PMB complaints, while restricted medical aid schemes accounted for 26.2% (*n*=294).

The number of PMB complaints throughout the 5-year analysis period is shown in Table 1. The average number of PMB complaints per year was 225.

Of the 1 124 complaints, 43.6% (*n*=490) were lodged by the members themselves, 37.3% (*n*=419) by a family member, 16.7% (*n*=188) by a healthcare provider, 1.2% (*n*=14) by a financial broker, 0.8% (*n*=9) by a legal advisor and 0.4% (*n*=4) by a healthcare facility. No complaints were lodged anonymously. All 1 124 complaints objected to the schemes' decision to not pay fully for the PMB-related treatment options or services offered to medical scheme beneficiaries by service providers.

A diverse number of PMB conditions were identified from the complaints and the top 10 most common conditions are listed in Table 2. The conditions were grouped as defined in the diagnosis treatment pairs (DTPs) of the 270 medical conditions included in the PMBs. Chronic diseases contributed 18.7% (*n*=210) of all PMB-related complaints. Cancer of the breast, prostate, oral cavity, pharynx, nose, ear, and larynx were in the top 10 list of DTPs most complained about.

Table 3 illustrates the top 10 CDL conditions about which members had payment complaints. The most common chronic disease identified in the complaints was diabetes (all forms) (18.1%, *n*=38/210). Twenty-eight of these diabetes-related complaints (73.7%) were not paid at all, while 10 (26.3%) were not paid in full.

Medicine and surgery comprised 50% of the complaints, with 29.9% (*n*=336/1 124) and 20.1% (*n*=226/1 124), respectively. The medical schemes rejected payment of 58.2% (*n*=654/1 124) of the PMB claims on the basis that the treatment or medicine did not form part of the scheme's protocols or formularies.

Discussion

This study was the first to evaluate clinical complaints about PMBs in SA beyond a single CMS reporting cycle. Over this analysis period, there was no significant change in the number of complaints analysed. The number of PMB complaints was highest in 2014. According to an investigation undertaken by the CMS, a majority of medical schemes do not apply alternative dispute resolution

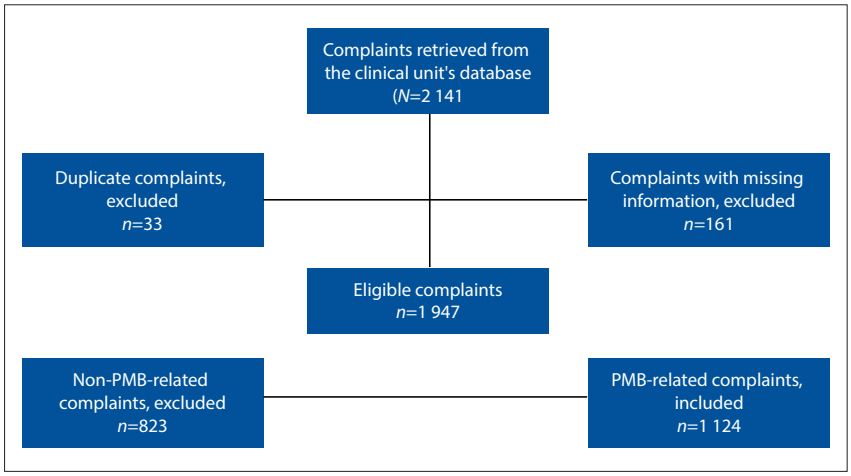

Fig. 1. Selection process for PMB complaints from January 2014 to December 2018.

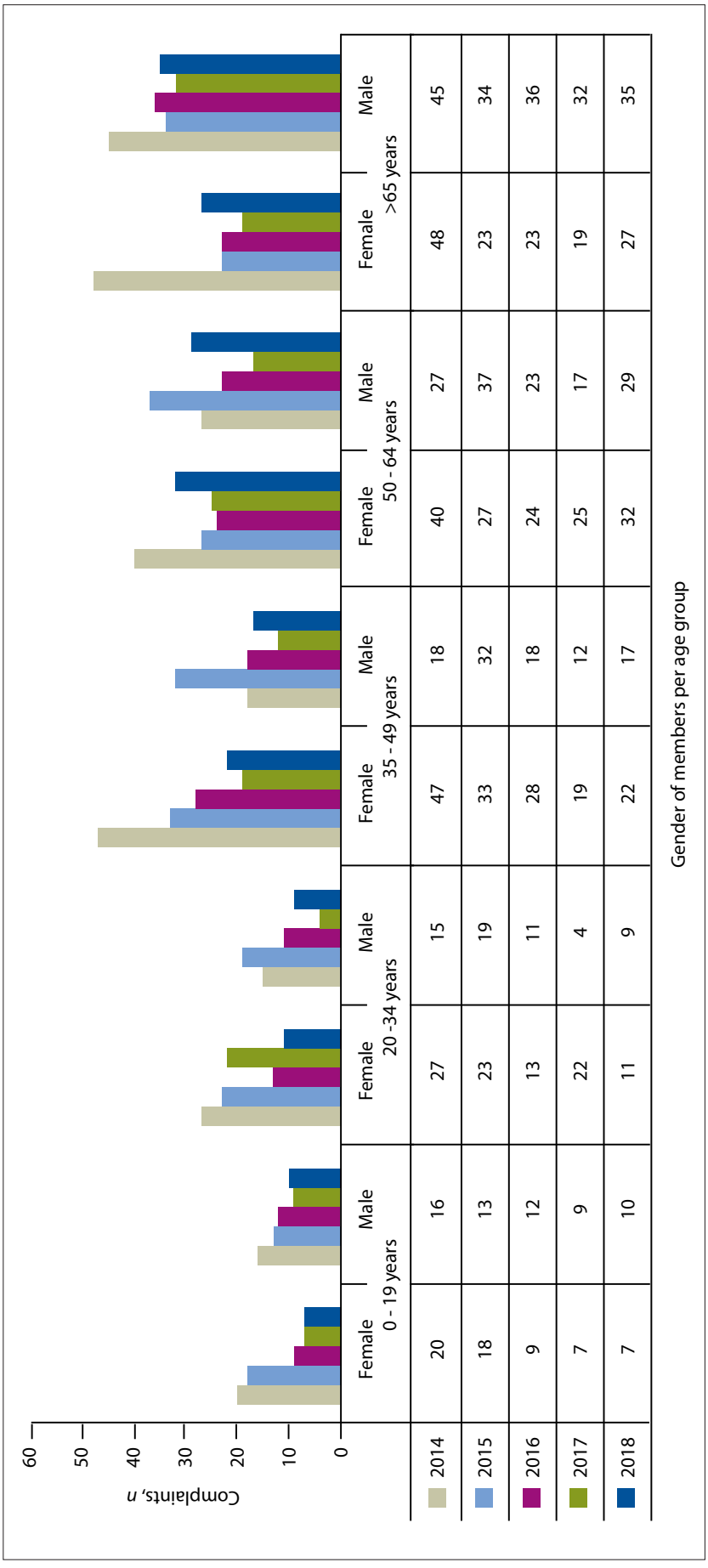

Fig. 2. Distribution of complaints across gender and age per year.

mechanisms as outlined in their registered rules, resulting in some members lodging their complaints directly to the CMS for resolution.[16] The high number of PMB complaints could also be due to medical scheme beneficiaries being dissatisfied with the internal resolution of their complaints at the medical scheme level.

The number of complaints was lowest in 2017. One of the CMS's strategic objectives is to formulate and publish PMB benefit definitions every year to ensure that medical scheme beneficiaries are adequately protected.[17] The PMB benefit definitions specify in-depth health technologies to be funded for PMB conditions with a substantial financial burden.[6] The purpose of publishing these documents is: to clarify medical scheme members' entitlements; reduce complaints and inquiries; and to expedite the resolution of medical management or payment-related concerns.[18] This intervention could explain the low number of PMBs complaints lodged in 2017.

The findings indicate gender differences; more complaints were related to female beneficiaries. Research suggests that this could be because women are sometimes treated differently to men when seeking care.[19] The number of female-related PMB complaints was higher than males in every age group, except for the ≥65 years category. This finding warrants further investigation as there are more female medical scheme beneficiaries compared with males.[6] This study also found that the elderly (≥65 years) lodged more complaints with the CMS, compared to the other age groups. This finding is supported by a study conducted in Brazil, which found that the elderly filed more complaints against their health insurance, despite being the smallest group of beneficiaries.[20] This finding is of concern as it suggests that beneficiaries often encounter difficulties receiving the health services that should be accessible to them as they grow older and more vulnerable.

More complaints were lodged by members who were the actual patients, a finding supported by Bark *et al.*,[21] who also noted that patients lodged more clinical complaints. In contrast, a study conducted in Australia found that 62% of complaints were lodged by advocates rather than by patients themselves.[14] While the study did not directly explore the factors that motivated people to complain, PMBs include life-threatening illnesses, which may motivate patients to lodge complaints.[22]

Table 1. Prescribed Minimum Benefits per year, *N*

Year	*n* (%)
2014	303 (27.0)
2015	259 (23.0)
2016	197 (17.5)
2017	166 (14.8)
2018	199 (17.7)

Table 2. Top 10 diagnosis treatment pair conditions members complained about (*N*=1 124)

PMB description	*n* (%)
Closed fractures/dislocations of limb bones/ epiphyses – excluding fingers and toes	48 (4.3)
Cancer of breast – treatable	40 (3.6)
Cancer of prostate gland – treatable	35 (3.1)
Acute and subacute ischaemic heart disease, including myocardial infarction and unstable angina	35 (3.1)
Pregnancy	28 (2.5)
Cancer of the oral cavity, pharynx, nose, ear, and larynx – treatable	27 (2.4)
Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	27 (2.4)
Acute leukaemia, lymphomas	26 (2.3)
End-stage renal disease regardless of the cause	23 (2.0)
Major affective disorders, including unipolar and bipolar depression	22 (2.0)
Other	813 (72.3)

Table 3. Top 10 CDL conditions members complained about (*N*=210)

CDL condition	*n* (%)
Diabetes	38 (18.1%
Hyperlipidaemia	29 (13.8)
Rheumatoid arthritis	24 (11.4)
Asthma	12 (5.7)
Cardiomyopathy	12 (5.7)
Dysrhythmias	11 (5.2)
Coronary artery disease	10 (4.8)
Crohn's disease	10 (4.8)
Hypertension	10 (4.8)
Chronic obstructive pulmonary disease	9 (4.3)
Other	45 (21.4)

Fractures, diabetes, and various types of cancers were common conditions that medical schemes disputed payment for, leading to member complaints. This contrasts with what has been reported in the USA, where health insurance often denies claims for mental health conditions.[23] In SA, an increasing number of beneficiaries are diagnosed and treated for multiple chronic conditions.[7] Such members typically claim four times the amount of a healthy member.[24] Research conducted in the USA suggests that denying legitimate claim payments is a costs-regulating strategy employed by medical schemes.[23,25]

Most complaints were related to the non- and/or short-payment of medicines and surgical interventions. This finding aligns with previous research conducted in Brazil, which revealed that medicines accounted for more than half of the complaints.[20] This is in contrast with findings from the USA, where laboratory services were the most frequently denied claims.[25] Our results are not surprising as the current DTPs do not specify which medicines and surgical interventions should form part of the PMBs. Medical schemes develop their own formularies based on evidence and decide which medicines to cover for each chronic condition.[26]

Study limitations

This study did not take into consideration the size (i.e. number of beneficiaries) of the two types of medical aid schemes in the analysis. Only the actual numbers were analysed; the annual rates were not calculated. The study did not look at the final rulings on the complaints, whether the Registrar ruled in favour of the beneficiaries or medical schemes. The use of secondary data was also a limitation because the data were originally collected for a different purpose to our study analysis.

Conclusion

Injuries and chronic diseases are the main conditions that medical scheme members complain about, while surgery and medicines are the main interventions complained about. The study highlights the need for revision of the PMBs to ensure a better understanding of entitlements. Interventions aimed at reducing the prevalence of chronic conditions need to be implemented, not only among medical scheme beneficiaries, but also across the entire country. The findings of this study can also be used by medical aid schemes and the CMS to educate members about the PMBs.

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