Summaries of National Health Insurance Bill, Medical Scheme Amendment bill, Health Market Inquiry findings and recommendations

1. Summary of National Health Insurance Bill, 2018

Government Gazette 41725, No, 635, dated 21 June 2018.

Comments to be submitted by 21 September 2018

The NHI Bill establishes the NHI Fund as an entity as well as associated Ministerial advisory committees. It sets out a phased approach with an initial focus on vulnerable groups of public sector patients and proposes a contractual framework for procuring services. No detail on a comprehensive package of services is included. Funding will be determined in consultation with National Treasury.

Part 1: National Health Insurance Fund

- NHI Fund is the single public purchaser and financier of health services
- The Fund is a mandatory prepayment health service system

Duties of the Fund include:

- Actively purchase services, medicines, health goods and health related products from certified and accredited suppliers
- Designing healthcare services on advice from the relevant committee of the Board
- Contracting with certified and accredited suppliers; and maintain service and performance profiles
- Establishing rule and mechanisms for payment of providers
- Annual price determination
- Monitoring standard and quality of healthcare services; and link provider payments to value of care delivered
- Undertaking the necessary analyses and research

Functions of the Fund include:

- Administrative functions such as employment, asset procurement, financial management
- Implement best practice for effecting the duties as above

Part 2: Right to Health Care

Eligibility as beneficiaries includes citizens, permanent residents and their dependents; children between 12 and 18; prison inmates. There are limited rights for asylum seekers and temporary residents.

Registration of users: eligible beneficiaries must register at accredited public or private facilities, based on accepted identification documents.

Rights of users: to receive quality services free of charge, access to information, access to services within a reasonable time period; protection of privacy; purchase complimentary services not covered by the Fund through a voluntary medical insurance scheme or out of pocket.

Reimbursement for service rendered: Users may access services at any accredited health establishment provided they adhere to referral pathways. The service may be denied if there is no cost-effective treatment. User may purchase services not reimbursed by the Fund through private health insurance.

Health service benefits coverage:

- The Fund will purchase comprehensive health service benefits, as determined by the Benefits Advisory Committee
- All NHI users to register with a provider of primary care services of their choice
- Specialist services only on referral
- Benefits Advisory Committee must take account of potential funds available
- The Committee must recommend service location, treatment guidelines and protocols

Cost coverage:

- Registered beneficiaries receive NHI services from accredited providers at no cost
- Failure to comply with referral pathways or those seeking services not medically necessary must pay directly or through private medical insurance.

Part 3: Board of Fund (p30)
Board of the Fund is independent and accountable to Parliament. Board of no more than 10 people appointed by Cabinet after the Minister's recommendation, having selected the nominees with requisite expertise through a public process.

Part 4: Chief Executive Officer (p36)
CEO establishes the following units: a fraud investigation, planning, benefits design, price determination, accreditation, purchasing and contracting, service provider payment, procurement, performance monitoring, risk and fraud prevention investigation; and liaison with the District Health Management Office. 3

Part 5: Ministerial Committees (p39)
- *Benefits Advisory Committee* to review health service benefits and treatment guidelines
- *Health Benefits Pricing Committee* – to recommend prices of health services to the Fund
- *Stakeholder Advisory Committee* –to advise Board and Minister on experience of services offered by the Fund
- Technical Committees – to be established as necessary achieve the objectives of the Act.

Part 6: General provisions applicable to operation of fund (44)
Role of Minister: The Minister has responsibility for governance and stewardship of the Fund.

Role of Department: ensuring implementation of national health policy; coordinating service provision at national, provincial and municipal level, integrating health plans at national and provincial level.

Ensuring provinces and municipalities provide services that the Fund may purchase.

Purchasing of health care services: Fund will purchase hospital services and reimburse directly to facilities based on DRGs, excluding district hospitals. At provincial level, including district hospitals, the funds may be transferred based on global budgets. EMS funded on a capped case-based fees.

Role of District Health Management Offices: facilitate, coordinate and manage provision of non-personal health services at district level.

Contracting Unit for Primary Health Care: contracts with Fund for primary care services per sub-district.

Accreditation of service providers by Fund: providers must be certified by OHSC and provide proof of professional registration. Adherence to pricing regimen. Accreditation valid for 5 years.

The Fund will contract with providers through the Contracting Units for Primary Health Care.

The Fund will contract directly with provincial and other healthcare facilities that meet requirements. Contracts to include clear performance expectations.

Payment of service providers:

- Payment for specialist and hospital services are all-inclusive
- Primary care providers paid based on risk-adjusted capitation through the Contracting Unit for Primary Health Care.

Part 7: Complaints and appeals
Complaints lodged with the Fund will be investigated by the Investigating Unit. Appeals may be lodged with the Appeal Tribunal.

Part 8: Financial matters
The Minister, in consultation with the Minister of Finance, will determine the budget and allocation to the Fund on annual basis.

Part 9: Miscellaneous
Offences: false information or false representation with the intention to obtain benefits or money, information disclosure without consent.

Minister may make regulations on operational matters concerning the Fund Transitional arrangements:

Phase 1, 2012 – 2017
Health system strengthening

Phase 2, 2017 – 2022
Continue with health system strengthening, develop NHI legislation and amend other legislation, establish NHI institutions, mobilize additional resources, selective contracting of healthcare providers.

Minister may establish the following Committees in Phase 2:

- National Tertiary Health Services Committee
- National Governing Body on Training and Development – health workforce planning and implementation oversight

- Ministerial Advisory Committee on Health Care Benefits for NHI as a precursor to the Benefits Advisory Committee
- Ministerial Advisory Committee on Health Technology Assessment for NHI as a precursor to the HTA Agency.

Objectives that must be achieved in Phase 2 include:

i. Central hospitals established as semi-autonomous entities

ii. Structuring of district level Contracting Units for Primary Healthcare Services

iii. Establishment of the NHI Fund and governance structures

iv. Implementation of a Health Patient Registration System

v. Health facility Inspection and certification by OHSC

vi. Purchasing of health service benefits at primary care level for priority programmes

vii. Purchasing of hospital services and other services, including EMS

viii. Changes to several related Acts

Phase 3, 2022 – 2026
Continue with health system strengthening, mobile additional resources, selective contracting of healthcare services from private providers. Objectives that must be achieved in Phase 3 include:

Operationalization of NHI Fund through a system of mandatory prepayment.

There are amendments to the National Health Act to include the National Health Insurance Fund and the District Health Management Office.

2. Summary of the Medical Scheme Amendment Bill
Government Gazette 41725, No, 636, dated 21 June 2018.

Comments to be submitted by 21 September 2018

Definition of Medical Scheme Beneficiaries
- Allows for the joint membership of a medical scheme and the NHI Fund.
- Dependent definition extended to include other family relationships and to include legal and factual dependents.

Definition of a Medical Scheme
- Definition of a medical scheme means any person or entity registered in terms of section 24 to carry on or operate the business of a medical scheme.
- Definition of the business of a medical scheme to include a combination of the functions – addresses demarcation gap.
- Medical schemes savings accounts refer to funds owned by the member, held in a trust by the medical scheme and does not form part of the assets and liabilities of the scheme.

Brokers
- Definition of brokers to only include those providing services on a commercial basis. Excludes company or union representatives who assist members on a non-commercial basis. Excludes

members from the Scheme office, trustees or employees of the administrator performing duties in a non-commercial manner.

- Broker fees defined as the fees a broker charges a member, or a fee the broker charges an employer. (This implies that members, not the Scheme, will pay brokers directly). Brokers must act with explicit consent from members.

  Broker services includes:

  - Advice to members when choosing a medical scheme
  - Ongoing service or advice regarding benefits
  - Does not include normal services provided by an administrator.

Scheme Office

- Principal Officer to be replaced by the positions of CEO and CFO.
- Key management personnel defined as management and board for purposes of relationships with all related parties.

Waiting periods and Open Enrolment

- Section 29A of the principal Act on waiting periods is repealed.
- A general waiting period is applicable to anyone who has not been a member of a medical scheme for a period of at least 90 days.
- No waiting periods may be imposed on any child dependent. o any treatment that was received within the 12-month period ending on the date on which an application for membership was made (the primary condition) and any further condition resulting from this primary condition.

New definition of condition specific waiting period:

- No waiting periods are applicable to beneficiaries changing medical schemes associated with their employment.
- Medical schemes may only cancel membership of members for a period not exceeding 6 months on account of the member committing fraud, failing to pay contributions or any other amounts due to the scheme, or non-disclosure. Contributions are payable during this period of suspended membership.
- The medical scheme may impose an administrative penalty on members reapplying to the scheme, where the scheme had previously cancelled membership.

Contribution rate structure

- A medical scheme must determine contributions for mandatory benefits based on income
- Child dependent rates must be set at 20% of an adult beneficiary
- Young adult (>18 years but <30 years) dependent rates must be set at 40% of an adult beneficiary
- A medical scheme may offer a discount for members choosing to use a DSP (efficiency discount option).

- For efficiency discounted options, a medical scheme must indicate the discount in contributions to parent plans in its contribution table
- The contribution table must specify the amounts allocated to risk pooled benefits and MSA, the amount to NHE, and the amount to broker fees. It is notable that broker fees are mentioned here.

Comprehensive service benefits

- The CMS and Minister shall determine a comprehensive benefit package
- Medical schemes must fund these benefits in full without co-payments or deductibles

Benefit Options

- Must be approved by the registrar
- A loss-making option will only be approved if it will not jeopardize the financial soundness of the scheme, and will be in the best interests of members
- The registrar may demand financial guarantees or impose requirements regarding reserves, additional to the statutory requirements to ensure the financial soundness of benefit options
- Should the Registrar believe a benefit option is not financially sound, then the Registrar may issue a directive to the scheme to withdraw the option or make amendments to the option. The registrar may put such amendments into effect subject to the provisions of the Promotion of Administrative Justice Act.
- The registrar may restrict medical schemes to provide cover that is not duplicative to the NHI fund.

Healthcare Providers

- The Registrar of the CMS is to establish a register of healthcare providers
- Medical schemes will be required to submit information on healthcare providers but not on patient diagnosis. This could include aggregate payment data.
- Medical schemes may elect not to make direct payments to providers not on the healthcare register.
- Definitions include:
    - Medical scheme tariff – the rate that the medical scheme reimburses providers
    - Provider fee – the rate that the provider charges the member

Operations the CMS

- The Consumer Protection Act does not apply to matters governed by this Act, nor does it apply to the powers of the registrar or Council
- The Public Finance Management Act applies to the CMS with sections 13 (auditor of the CMS) and 14 (annual reporting of the CMS) of the principal Act repealed.
- Any money payable to the CMS is recoverable by the Registrar
- Functions of the CMS include: o Collect information about any aspect of private healthcare including information on prices, utilization, and costs of healthcare services. Information should not contain any personal medical or diagnosis information of members.

- Establish a Central Beneficiary Registry
- Establish a central registry of healthcare providers
- Support the NHI fund, and share available resources and expertise with the NHI fund

Powers of the Registrar

- Registrar may direct a medical scheme to amend its rules
- Where a medical scheme fails to amend its rules, the Registrar may proceed to amend the rules directly
- The registrar may restrict the scheme's non-healthcare expenditure
- The registrar has powers of inspection over a medical scheme
- If a scheme fails to amend the rules upon instruction of the registrar, the registrar may amend the rules directly
- The costs of the actions required by the registrar shall be borne by the medical scheme

Central Beneficiary Register

- Information may not include identification details such as names, date of birth, addresses, identification numbers, etc.

Complaints and Disputes

- The registrar shall publish guidelines about the dispute resolution mechanisms that must be included in the scheme rules
- The medical scheme must address all member complaints within reasonable time lines
- Members may complain directly to the registrar
- Any person may appeal a decision of the registrar to the Appeal board
- An appeal does not suspend any decision of the registrar pending the outcome of the appeal
- The Appeal board will be appointed by the Minister
- The registrar and any party to an appeal may be represented by a legal representative of choice at his or her own expense
- The Appeal board must conduct its hearings in public

Governance of Medical Schemes

- Every medical scheme must be managed by a board of trustees
- Board must comply with fit and proper requirements (existing trustees exempted).
- Board must include individuals with specific qualifications.
- The Minister may prescribe the term of office of the board
- Duties of the board is to provide strategic oversight and direction to the medical scheme and include:
  - Ensuring an electronic version of the tariffs of the medical scheme are publicly available on the scheme's website .

- An appropriate level of professional indemnity insurance and fidelity guarantee insurance is taken out and maintained by the scheme
- To approve any contract or occurrence of expenditure in accordance with the transformation charter
- To ensure the executive structure of the scheme is appointed in accordance with the transformation charter

- The registrar will publish parameters which medical schemes must apply in the remuneration of their board of trustees and executives

- Scheme officers cannot be officers of multiple schemes

3. Health Market Inquiry (HMI) findings and recommendations

The HMI Process commenced in 2014 and considered the private healthcare sector in South Africa. The investigation included public hearings, seminars and analysis of submitted data. The provisional report was released on 5 July 2018 and commentary is invited with a closing date of 7 September 2018 and a final report will follow. The provisional report notes that there are some fundamental differences of opinion between the HMI technical team and stakeholders on some of the issues including profitability and conclusions of the analytical work and that this will be addressed further in the final report. The provisional report is extensive and some of the findings and recommendations are noted below.

1. Scheme Benefits, consumers and role of Administrators

The HMI finds that:

- Scheme options are highly complex, and cconsumers cannot effectively compare options, and are confused. This is in part due to the incomplete regulatory environment. The HMI does not agree that option complexity reflects innovation by schemes.

- Schemes demand almost no accountability from administrators to manage supply-induced demand and moral hazard.

- Schemes and administrators are not using buying power effectively.

- There is limited evidence of value-based contracting by medical schemes.

- Brokers play an important role in assisting members to navigate scheme complexity.

- Anti-selection has adversely affected medical schemes and it is not clear whether current measures provide adequate financial offset.

The HMI recommends that:

- Scheme options be restructured to include a base benefit option which is standard across all schemes, and that this option would be risk equalised across schemes through a risk adjustment mechanism (RAM). Schemes would then be free to provide supplementary options which may be risk rated.

- The current tax credit regime should be reconstituted to take the form of a cross-subsidy administered through RAM to address the needs of low income members.

- The PMB package for the base benefit option would be regularly reviewed (at least every 3 years) with more detailed information provided to members on accessing PMBs. PMBs need to include more out of hospital cover to reduce incentives for admissions.

- Governance of schemes should be strengthened, and Trustees should demand more accountability from their administrators to manage claims inflation.
- Remuneration for scheme officers should be capped and linked to scheme performance.
- There should be public reporting of the outcomes of managed care arrangements in terms of savings achieved.
- Schemes need to be more actively encouraging AGM participation by members and members should be made more aware of the CMS.
- Brokers should be remunerated on an opt-in basis with full disclosure of fees.
- A discount to encourage younger members to enter earlier should be considered.
- Competition in the schemes market should be increased by the introduction of 'regional' schemes, which could be protected from volatile claims risk through reinsurance.

2. Suppliers of Healthcare

The HMI finds that:

- Practitioners are key drivers of health expenditure overall and peer review mechanisms have limited effect.
- There is evidence of specialists acting in collective ways that have driven up costs.
- There has been a failure to properly explore multi-disciplinary models of care delivery and the fee for service model stimulates over servicing.
- There is a lack of accountability in terms of reporting of outcomes.
- There is evidence of supplier induced demand including increases in the number of private hospital beds driving admission rates and inappropriately high rates of ICU admissions. It was also noted that facilities are competing to attract specialists (with factors such as new technology).
- There is not an under supply of specialists but rather an inefficient use of their time.
- The private hospital market is highly concentrated with 3 hospital groups dominant. They have exhibited sustained profitability and there has been a low tendency to adopt alternative modes of delivering hospital care. The NHN exemption appears to have been effective from a competition perspective.
- Provider networks are a promising tool for promoting an effective outcomes-based approach.
- There has been inconsistent application of licensing processes across the provinces which has led to an oversupply of hospital beds.
- There is lack of transparency in pricing and lack of reporting on outcomes and the overall lack of publicly available information affects decision-making by consumers and practitioners. This data is also required to facilitate risk adjustment.

The HMI recommends that:

- There are detailed reporting requirements for facilities and a new licensing framework under a Supply Side Regulator for Health (SSRH) which would be established under the National Health Act.

- The SSRH would be an independent public entity and would oversee proper healthcare resource planning and monitoring.
- A moratorium on new beds for the 3 large hospital groups should be considered.
- Practice code numbers for public and private facilities should be managed by the SSRH. Practitioners must also register the facilities at which they operate to allow for inspections and prevent fraud. The OHSC would be incorporated into the SSRH.
- Economic value assessments should be published to stimulate competition, mitigate information asymmetry and facilitate strategic purchasing by funders.
- The Outcomes Measurement and Reporting Organization (OMRO) should be implemented in a phased way with the first phase being a voluntary measurement and reporting system leading to the establishment of a statutory entity.
- The CMS should include metrics on supplier induced demand in its published reports and work with stakeholders to determine appropriate format and frequency.
- The public sector should be engaged in strategic purchasing from the private sector.
- The HPCSA must undertake a review of its ethical rules to encourage group practices and global fees and to remove the ban on the employment of doctors by facilities. The rules should consider the competition perspective in general. Specific rule references have been provided and this includes full disclosure of the practitioners interest in treatment provided including facility shareholding and financial interests in medicines and products used or dispensed.

3. Provider pricing

The HMI finds that:

- Fee for service tariffs are a reflection of market failure as they do not consider quality of care and they promote supplier induced demand.
- A review of the 2004 order is not required but collective bargaining should be facilitated by the SSRH.
- Provider networks have a net positive impact on competition and are beneficial to consumers in terms of treatment with no balance billing. They also benefit providers due to contractual certainty.
- Selective contracting on patient volumes, price and quality is required for alternative reimbursement models (ARMs) to be effective.

The HMI recommends that:

- There are two proposals for addressing tariff setting:
    - Regulated pricing: this will require meaningful participation by all stakeholders with submissions on tariffs. The SSRH will then publish FFS tariffs which are only binding on PMBs. There would be an appeal mechanism to an arbitrator for stakeholders.
    - Multilateral forum: this would be managed by the SSRH to determine tariffs. There would be a formal engagement/bargaining process leading to tariffs being set by the SSRH which would also only be binding on PMBs and a reference point for other benefits. There would be provision for appeals to an arbitrator.

- Bilateral negotiation and the development of ARMs should be encouraged.
- Coding systems need to be standardised across the health sector. This will be coordinated by the SSRH.
- Provider network agreements need to promote transparency in terms of pricing, health outcomes and location with reasonable access a key consideration. Contracts need to measure and reward quality care. Balance billing should not be allowed under network contracts.
- Facility and pathology DSP arrangements need to be more competitive and involve open tender processes.