

South African Private Practitioners' Forum

Submission on Draft MSA Bill to the National Department of Health



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Introduction

1. The South African Private Practitioners Forum (SAPPF) is a voluntary association of private practitioners working in the South African private health sector. The organisation has a membership base of approximately 3000 specialists representing most specialist disciplines, as well as 3500 other practitioners, including General Practitioners and ancillary healthcare practitioners. SAPPF acknowledges the transformative elements in the Constitution of the Republic of South Africa, 1996 (the Constitution) and the Constitution's commitment to improve access to health care. Furthermore, our humanity compels us to work towards quality universal access to health care for all of our citizens, within the constraints of resources in Government.
2. The National Department of Health (the DOH) published the draft Medical Schemes Amendment Bill in the *Government Gazette* 41726 on 21 June 2018 (the Draft MSA Bill) and afforded stakeholders 90 days to submit comments on the Draft MSA Bill. SAPPF (and the medical professionals it represents) is an important stakeholder in the healthcare industry, and accepted the opportunity to submit comments. Given the fact that the draft National Health Insurance Bill, 2018 (the Draft NHI Bill) was published at the same time as the Draft MSA Bill, SAPPF requested an extension of the time period to submit comments. SAPPF unfortunately did not receive a response to its request. The extension would have enabled SAPPF to have made more detailed submissions but it has managed to compile these high level submissions in the limited timeframe afforded to it.
3. Before commenting more substantively on the contents of the Draft MSA Bill, we wish make the following two initial comments which underlies a number of SAPPF's comments in the paragraphs below:
 1. *first*, there are a number of inconsistencies between the Draft MSA Bill and the Draft NHI Bill which, among other things, makes it unclear how the national health insurance (the NHI) regime and the medical scheme regime will function together. It is thus strongly recommended that the Bills be aligned to ensure a more consistent and co-ordinated regulatory framework; and
 2. *second*, the Draft MSA Bill purports to increase the powers of the Registrar of Medical Schemes (the Registrar) rather extensively which is, as will be explained in further detail below, inappropriate in our view.

4. The future of health care in this country is vital, not only to our membership and other participants in the health care industry, but to all South Africans. SAPPF would like to positively contribute to the debate and in doing so makes the following submissions on the Draft MSA Bill.

SUBMISSIONS ON THE DRAFT MSA BILL

Definitions

A number of definitions present concerns:

5. "Condition Specific Waiting Period" – the additional insertion of a "further condition the primary cause of which is a condition referred to in paragraph (a)" creates an additional barrier to patients accessing healthcare. It is unclear how this will be interpreted and the degree to which a secondary condition can be linked to the primary condition. The nexus between the secondary condition would need to be proved. This would be a complex matter particularly in cases of multiple diagnoses.
6. "Dependant" – The new proposed definition of dependant replaces the phrase "member's immediate family" to include "any other relative of the member...". This broadens the group of individuals that may be regarded as dependants. This insertion is to be welcomed.
7. "Designated Service Provider" – This new definition amends the previous reference to Designated Service Providers (DSPs). The conceptual change is that previously under the Regulations in terms of the Medical Schemes Act, published under Government Notice R1262 in *Government Gazette* 20556 of 20 October 1999 (the MSA Regulations), DSPs were contracted to provide services in respect of prescribed minimum benefits. This definition refers to those healthcare providers who are selected by the scheme and contracted to provide relevant healthcare services to its members. The use of the word "relevant" will require clarification.
8. "Managed Health Care" – This definition introduces the concepts of "rules-based and clinical management-based programmes", however there is no definition supplied for these integral concepts. Greater clarity is sought with reference to these concepts and it is submitted that they be properly defined in this Definition clause. Additionally, any managed healthcare intervention cannot and must not preclude the use of evidence-based medicine.
9. "Medical Scheme Tariff" - is defined as the "unit or value, generally corresponding to the fees ... negotiated". However, unless a system of collective bargaining or price setting is implemented, as proposed by the Health Market Inquiry (HMI), this definition will not solve the complaints by both sides, that tariffs are unilaterally determined. "Provider fees" are then defined as a "chargeable price, fee or tariff", which means that it could only be levied if "chargeable",

thereby hinting at, but not providing for, some type of price regulatory measure. We also note that although these terms are defined, they are not used in the body of the Draft MSA Bill.

10. “Risk-pooled benefits” is also a new definition, describing that such benefits amount to cross-subsidisation. As pointed out by the Provisional Findings and Recommendations of the Health Market Inquiry (the HMI Report), in the absence of a risk-equalisation, or risk-adjustment mechanism, some schemes and options remain at risk of adverse selection. It is not clear why there is no proposal to implement this important measure, which was, from the start, to be part of the larger medical scheme reforms.

Exclusion of the Consumer Protection Act

11. The Draft MSA Bill seeks, at section 2A to exclude the operation of the Consumer Protection Act, 2008 (the CPA) in relation to matters governed by the Medical Schemes Act, 1998 (the MSA), essentially exempting individuals from the protections afforded by the CPA when dealing with medical schemes or with the Council for Medical Schemes (the CMS).
12. The CPA affords protection to individuals as consumers. By the very definition individuals who are beneficiaries or dependents are purchasing a product from a medical scheme and are therefore consumers. Such individuals would therefore be in a disadvantaged position in respect of seeking redress (in terms of the CPA) in any matters addressed by the MSA.
13. The CPA makes clear provision for a process whereby a regulatory authority, such as the CMS, may apply for, and obtain, an industry-wide exemption from the application of the CPA. This provision is contained in section 5(3) of the CPA.

*A regulatory authority may apply to the Minister for an industry-wide exemption from one or more provisions of this Act on the grounds that those provisions overlap or duplicate a regulatory scheme administered by that regulatory authority in terms of—
any other national legislation; or
any treaty, international law, convention or protocol.*

*The Minister, by notice in the Gazette after receiving the advice of the Commission, may grant an exemption contemplated in subsection (3)—
only to the extent that the relevant regulatory scheme ensures the achievement of the purposes of this Act at least as well as the provisions of this Act; and
subject to any limits or conditions necessary to ensure the achievement of the purposes of this Act.*

14. An analysis of the current provisions of the MSA Act and the proposed amendments contained in the Draft MSA Bill do not, in our view, contain comparable protections afforded to the individual by the CPA.
15. It is our submission therefore that the insertion of section 2A in the Draft MSA Bill be removed in its entirety, as well as the reference in the preamble to the exclusion of the application of the CPA.
16. Should the provisions relating to the exclusion of the CPA be retained, we submit that the blanket exclusions currently provided for be amended to provide for specific exclusions, and in particular, reference should be made to section 5(5) of the CPA, which provides that:

If any goods are supplied within the Republic to any person in terms of a transaction that is exempt from the application of this Act, those goods, and the importer or producer, distributor and retailer of those goods, respectively, are nevertheless subject to sections 60 and 61.
17. This is particularly pertinent in respect of medicines and medical devices. Where, as part of managed care and benefit design, certain formularies and treatment protocols are prescribed and must be adhered to by healthcare providers. To remove such protections afforded by the CPA in respect of medicines and medical devices would place beneficiaries in an unreasonably disadvantaged position.

Functions of Council

18. Clause 4 which introduces amendments to section 7 of the Act makes provision for an expansion of the collection and dissemination of information about private healthcare. The scope of this information has been broadened to include the function to disseminate information about any aspect of private healthcare. These aspects are to include information relating to prices, utilisation and costs. It is unfortunate that the Draft MSA Bill repeals the requirement for the CMS to produce an Annual Report as this more closely described function would assist in disseminating this information to the public and specifically the private healthcare industry.
19. It is notable that the expanded description of information to be collected by the CMS relates to all aspects of the private healthcare sector. The CMS is not confined in any way. We submit that this presents an opportunity for the CMS to collect and disseminate accurate information relating to the input practice costs relating to the provision of services by private healthcare practitioners. Further an opportunity for the CMS to collect costing information related to imported pharmaceuticals, medical devices (including radiological devices). This would assist in

having accurate cost input information that would dispel any misperceptions relating to the viability and sustainability of rendering high quality healthcare.

20. Section 7(f) of the Draft MSA Bill makes reference to CMS Circulars that the CMS already publishes. It is unclear whether the purpose here is to grant such Circulars legally binding force and effect. The wording of the section states that the rules and Circulars would be made for the purpose of “the performance of its functions and the exercise of its powers”. If the intention is for the Circulars to be legally binding, this must be expressly provided for although we submit that this would be inappropriate as the Circulars have been treated as a communication tool as between the CMS and the industry.

Relationship with the NHI Fund

21. The introduction of section 7A in the Draft MSA Bill provides a clear intention of integration with the NHI Fund intended to be created in terms of the draft NHI Bill.
22. While the integration and obligation on the CMS to support the NHI Fund in its objectives is laudable, work will still need to be done in respect of inconsistencies and other unintended contradictions between the Draft MSA Bill and the Draft NHI Bill.
23. The proposed section 7A(b) requires the CMS to cooperate with the NHI Fund in making recommendations to the Minister on service benefits. This is reinforced by the representation that the CMS would have on the Benefits Advisory Committee of the NHI Fund in terms of section 25 of the Draft NHI Bill. Further to this, the Minister may determine additional matters on which the CMS will be obliged to cooperate with the NHI Fund. Section 7A(c) also compels the sharing of “available resources, expertise and processes” with the NHI Fund. As the CMS is a well-established and functioning entity, it is anticipated that the NHI Fund will rely heavily on the resources, expertise and processes already in place. It is possible that the CMS will become something akin to the National Health Insurance Authority (NHI Authority) that was described in the National Health Insurance White Paper, 2017 although not mentioned in the current Draft NHI Bill.
24. The CMS being compelled to “support”, “co-operate” and “share resources” with the NHI Fund in effect means that medical scheme members, whose schemes’ levies fund the CMS, will be co-funding the NHI Fund’s work.
25. Our submission in this regard is that the CMS is a distinct regulatory authority whose scope is within the private healthcare sector. While information obtained from the CMS would be of value to the NHI Fund, it would, in our view be undesirable to have the CMS function as the *de facto* NHI Authority.

26. It is presumed that section 8A, which allows the CMS to obtain from medical schemes information including the professional registration number of healthcare providers, their practice number, number of unique beneficiary visits/admissions, the total amount claimed by the healthcare provider and amounts paid from risks and savings is intended to allow the CMS to pass this information on to the NHI Fund as part of the support function of the CMS to the NHI Fund.

Repeal of sections 13 and 14 of the MSA, Accounting Officer and Annual Report

27. It is presumed that the repeal of section 13 of the MSA arises from the inclusion of the CMS as a public entity in Schedule 3 of the Public Finance Management Act, 1999 (PFMA) and as expressly stated in clause 3 of this Draft MSA Bill.
28. However, the difficulty arises where, in terms of section 40 of the PFMA, the Registrar will only be required to report to the Auditor General and National Treasury. There is no obligation, in terms of the PFMA to publish financial statements to the public.
29. This change indicates a move away from transparency of financial reporting of the CMS, which is further confirmed by the repeal of section 15 of the MSA that imposed a statutory mandate on the CMS to publish its Annual Report. This repeal is disappointing, especially in light of the fact that the CMS Annual Report provided an outstanding source of useful information to the private healthcare sector.

Central Beneficiary Register

30. The Draft MSA Bill, at clauses 19A and 19B, provide for the establishment and purpose of a Central Beneficiary Register.
31. The CMS must, by Notice in the *Government Gazette*, establish and maintain the Central Beneficiary Register, containing such information as may be prescribed. It is not clear what type of information will be contained on the Central Beneficiary Register, however, information on the beneficiary's name, date of birth, address, identity number, medical scheme membership number or health status of the beneficiaries is expressly excluded in terms of section 19A(1).
32. This represents a new development from the previous "Central Repository of Medical Scheme Members" which had been envisaged and requested by the Minister from the CMS in July 2016, in which the DOH requested all medical schemes, administrators and private healthcare

funding entities to furnish the CMS with regular updated electronic records pertaining to basic personal, demographic (including domicile) details of all members and their beneficiaries.

33. Section 19A(1) is a welcome progression in respect of protection of the beneficiary's personal information, in line with the Protection of Personal Information Act, 2013 (POPI), the National Health Act, 2003 and other legislation.
34. However, in light of the objective of the Central Beneficiary Register as stated in section 19A(2), it is assumed that the data that will be contained in the Central Beneficiary Register will originate from claims submitted to medical schemes by their members, which information will contain the personal information of beneficiaries expressly excluded in to section 19A(1). Although the term "health status" is not defined, it is our understanding that if information on claims is submitted to the Central Beneficiary Register, the health status of a beneficiary would be revealed. The same would apply to visits to a healthcare provider or health establishment.
35. To ensure that the protection afforded to beneficiaries in section 19A(1) is given effect to, we suggest that express provision is made for any data that is submitted by medical schemes or the NHI Fund, to be de-identified, i.e any personal information of beneficiaries contained in claims submissions must be removed either on the Register itself or if it is to be disclosed to the Fund.
36. It is further unclear whether the intention is to include data pertaining to beneficiaries who are eligible to obtain benefits under the NHI Fund but who are not members of a medical scheme. If such inclusion is intended, then the information used in the "identifying and assessment of risks within medical schemes" would be skewed as it would contain data of individuals who are not members of medical schemes. Similarly, where medical scheme members elect to register as users/beneficiaries of the NHI Fund, there will be instances where those persons access healthcare via the Fund and not claim for those services from their medical scheme.
37. As the collection of the information results from personal information being submitted to medical schemes solely for the management of a claim, the further processing of such information would constitute further processing of information which is limited under POPI.

Admission of Beneficiaries and Cancellation of Membership

38. This Draft MSA Bill, at clause 11, repeals Section 29A of the MSA which previously governed waiting periods. Section 32B now proposes new waiting periods. These could, in the absence of a risk adjustment mechanism for schemes, have serious implications on the affordability levels of schemes, and the benefits available on a scheme option. It is submitted that recommendations

made by the HMI in respect of risk adjustment mechanisms have not been be considered for inclusion in this Draft MSA Bill.

39. Section 32A entrenches open enrolment, namely that open schemes must take on all persons who apply, and restricted schemes cannot refuse to admit dependents. It also states that, had membership been terminated, as permitted in the law, re-enrolment cannot be prohibited. As stated previously, open enrolment without the remaining parts of medical schemes reform proposed in the HMI Report, namely risk adjustment and mandatory membership, could pose a financial risk to schemes.

Contributions by various classes of beneficiaries

40. Sections 32E to H govern various aspects of contributions. Medical schemes are required to adhere to strict legal rules prohibiting activities that could relate to possible risk-rating, but similarly cannot benefit from mandatory medical scheme cover and risk equalization. Unless these issues are addressed the continued viability of medical schemes is jeopardised.
41. Section 32E imposes community rating and prohibits contributions to be set on age, any non-discrimination ground, health status, utilization and any other factor that may pose an adverse financial risk to the scheme. This amendment requires schemes to take on adverse financial risks, but does not provide any mechanism to assist schemes in managing this risk.
42. Section 32F(2) sets the contributions of children at no more than 20% of the adult contribution, and for young adults at no more than 40%. It remains to be seen whether this is a restriction that is sustainable for medical schemes. These percentages are also random, and not motivated or justified.
43. The scheme must specify, in a contribution table, under section 32H, per benefit option, the contributions per class of beneficiary. This is a welcome insertion as it provides a clear picture of how the amounts received by schemes in contributions are allocated.

Discounts for utilising designated service providers

44. Section 32G states that a scheme may, but is not obliged, to provide a uniform percentage discount on the payable contributions for a specific benefit option where the member elects to only have services provided by a DSP. This discount must be approved by the Registrar.
45. The member would be bound by their choice to receive services from a DSP. No provision is made in this section for circumstances where the member, due to circumstances beyond their

control, obtains services from a non-DSP provider. We assume that the regime created by Regulation 8 of the MSA Regulations, which deals with the circumstances where the member involuntarily obtains services from a non-DSP, will still apply. In terms of regulation 8, provided certain criteria are met, there are no co-payments owing by the member where there was an involuntary use of a non-DSP. This section does not state what will occur in respect of a member's contributions should they initially make the selection to receive services from a DSP but, during the course of their membership subsequently obtains services of a non-DSP.

46. In the event that the comprehensive service benefits regime is implemented, it will require an amendment to, or possibly a repeal of, the prescribed minimum benefit (PMB) regulations.

Benefits

Comprehensive service benefits

47. Section 32I introduces comprehensive service benefits and health services relating to those comprehensive service benefit conditions that must be determined by the CMS and be published by means of a Notice in the *Government Gazette*. There is a concern that this section does not make formal provision for inputs or consultation from healthcare providers. It is apparent that the intention is to move away from the current diagnosis-based system that underpins the PMB regime, but the input of healthcare providers would nevertheless be critical in ensuring that the decision on which service benefits and health services to include contains a clinical component and not be based solely on cost considerations. It is acknowledged that the section makes provision for public comment, but it is submitted that involvement of healthcare providers should occur prior to publication of the Notice.
48. The Draft MSA Bill does not provide a definition for "service benefits" and whether or not these benefits would include coverage of the costs of medicines, medical devices and subsequent treatment services. The implications of this could be severe for patients whose conditions do require more extensive professional services, medicines or medical devices. There would not be real processes of rationing or priority-setting.
49. The absence of a definition for "service benefits" is aggravated when considering the meaning of section 32I(1)(b) which states that the Notice must specify relevant health services in relation to comprehensive service benefit conditions referred to in subsection(a). There appears to be a distinction between the concept "service benefits" and "health services" in respect of those benefits. One would assume the benefits referred to would actually refer to the health services that are to be paid for in full by the medical scheme in terms of the new section 32I(2), as this

would be a logical understanding, but section 32I(1) treats benefits and health services as two separate concepts. We then return to that question exactly what is a “benefit”. Therefore, it is our submission that there must be a clear and precise definition of “service benefit”.

50. The CMS is currently undertaking a PMB review. We understand it includes discussions on services in general categories, such as maternal health and rehabilitation. It may be useful to make reference to this process in determining the comprehensive service benefit package. Our experience in attending these meetings is that the current process is aimed at creating the service package.
51. Medical schemes will, in terms of Section 32I(2), be obliged to pay the cost of any “relevant health service”, and if there are no relevant health services determined, the costs association with a condition. The section further authorises the CMS to determine limitations or conditions on what costs schemes must pay in full without co-payment or the use of deductibles for these relevant health services. It is not clear what is meant by the term “costs” in this context.
52. This is the only reference in the Draft MSA Bill to the prohibition of co-payments, which does not align with the numerous public statements by the Minister that co-payments would be “abolished” in these amendments to the Act. The current Regulation 8 already prohibits the charging of co-payments and use of deductibles with wording that is almost identical to the wording of this section. Regulations 15H and 15I also currently prohibit co-payments under certain circumstances. The only change to the current system is thus the replacement of the PMBs with the Comprehensive Service Benefits – the payment system for these benefits appears to be unchanged.
53. This section further makes no reference the limitation or “capping” of costs for the comprehensive service benefits.
54. It is unclear exactly how the CMS, the NHI Fund and the Minister will determine the cost of health services. Our understanding of the term cost is that it is a concept which includes input costs (consumables, equipment costs, facility fees etc.). It also remains unclear what a “service” is. For example, in hip replacements, is the service the services rendered by healthcare professionals (surgeons, anaesthetists, physiotherapists, etc.), the facility and/or the products (medicines, devices and equipment), separately, or are all collectively a single “service”. If the benefit “costs” are capped, certain assumptions will have to be made in relation to the range of medicines and medical devices that could be used, as well as any possible outliers that might require different medicines or devices (e.g. due to adverse events, or specific clinical profiles).
55. No provision is made in this section for the frequency of review of the comprehensive service benefits. There should be a review conducted on a regular basis to ensure that the services keep

pace with advancements and improvements in medical treatment, pharmaceuticals, medical device etc. This section should make provision for such a mechanism.

56. Given the importance of this particular amendment and its impact on medical schemes, scheme members and healthcare professionals, it is our submission that the terminological matters we have raised above be addressed and clarified to ensure legal certainty on the rights and obligations of all role players.

Healthcare Providers Register

57. Section 32J of the Draft MSA Bill makes provision for the creation of a Health Care Providers Register. It will be a register not only of healthcare providers, but also of healthcare establishments.
58. There is a peculiarity in the wording as section at 32J(b)(i) refers to services provided by a natural person and in 32J(b)(ii) to services rendered by a non-natural person. From our reading of the section the former refers to healthcare providers whilst the latter should refer to health establishments. We submit that the use of the terms “natural” and “non-natural persons” be replaced by healthcare provider and health establishment respectively.
59. Section 32J(1)(c) imposes a registration requirement on both healthcare providers and health establishments. It is not clear why subsection 3(a) provides medical schemes with the option not to pay a healthcare provider directly if that healthcare provider is not registered on the Healthcare Providers Register but the same option is not granted in respect of health establishments. Although this section does not make it mandatory for healthcare providers to register, in order to ensure direct payment from medical schemes, they will have no choice but to register.
60. In terms of this Draft MSA Bill and the draft NHI Bill, healthcare providers will have to obtain registration from at least four different regulatory authorities, namely 1) their professional regulatory authority (Health Professions Council of South Africa (HPCSA), South African Nursing Council, South African Pharmacy Council etc), 2) the DOH in respect of the Certificate of Need, 3) the NHI Fund for accreditation and 4) the CMS for the healthcare providers register. These registration requirements are interconnected and have differing periods of validity before renewal is required. This creates a difficult landscape for the healthcare provider to navigate, as well as additional bureaucracy and costs. The HPCSA registration number, without which medical practitioners are unable to practise, should be utilised as the only identifier for the healthcare provider in respect of medical schemes. This number should be used as the identifier

for both registration of a healthcare provider with their professional regulatory authority as well as the proposed “Healthcare Providers Register”. This would serve, at least in part to simplify the administrative tasks relating to the issuing of unique numbers to healthcare providers for registration with the CMS.

61. The information in the Register and the issuing of a unique number (section 32J(1)(d)) appears to be similar to the information required under the current Practice Code Numbering System managed currently by the Board of Healthcare Funders of Southern Africa for the CMS. It is not immediately apparent whether the requirement for the Practice Code number will remain unaffected by this Draft MSA Bill and clarity is sought in this regard.

Approval and Withdrawal of Benefits

62. Section 33(1)(b) will require regulations to be published to prescribe what information will be required to be submitted by schemes in order to obtain approval for the intended benefit option they wish to offer. This application would require the submission of a business plan and information on the viability of the option and the scheme as a whole. The Registrar will have the power to demand financial guarantees and to impose any requirements regarding the reserves of a scheme.
63. The Registrar has the authority in terms of section 33(4) to require a benefit option to be withdrawn and amended and should a scheme so directed fail to amend their rules as directed by the Registrar, subsection (5) authorises the Registrar the right to effect those amendments him/herself.
64. There is thus significant authority vested in the Registrar to scrutinise the implications of benefit options on the financial status of a medical scheme. As this would require specialised expertise in financial and risk management, it would therefore be prudent to include a provision that the Registrar utilises the services of an appropriately qualified and experienced person to assist in making these assessments.

Prohibition of Certain benefits

65. Section 34 is amended to add subsection 3 which empowers the Registrar, after consultation with the Minister, to restrict the extent of benefits that medical schemes may provide where the services and benefits are available under coverage by the NHI Fund. The rationale for this is to eliminate duplicate costs for the same benefit. This proposed amendment is significant. Our concern with the inclusion of such a power is two-fold.

66. *First*, the provision appears to be in conflict with what is provided for in the draft NHI Bill. In terms of clause 10 of the Draft NHI Bill, a person may purchase health services not reimbursed by the NHI Fund through any other private health insurance scheme or may make out of pocket payments. Clause 11 of the Draft NHI Bill provides that a person, who is not entitled to health service benefits purchased by the NHI Fund, who failed to comply with referral pathways or who seeks services that are not deemed medically necessary by the Benefits Advisory Committee, must pay for the services directly, or through a voluntary medical insurance scheme or through any other private insurance scheme. It is therefore clear that the NHI Bill contemplates instances where benefits are provided for both under the NHI Fund and medical schemes or private insurance schemes.
67. *Second*, the implication of this section is that, should the Registrar exercise this power, users will be unable to "opt out" of the NHI scheme for services covered by the NHI Fund and choose to be covered by private medical schemes instead.
68. It is not clear why the word "coverage" only is used, and not "reimbursed" or "reimbursement". As noted above, health services that are covered may, for a number of reasons specified in the Draft NHI Bill, not be reimbursable.
69. This section, while requiring the Registrar to "have regard" to health services covered by the NHI Fund, does not restrict the Registrar from prohibiting medical schemes from offering cover that are not covered by the Fund either. This creates the risk that persons may be left without cover in respect of health services excluded under both the NHI and MSA Bills. These persons may have private health insurance as their only option.
70. We submit that the proposed inclusion of subsection (3) to section 34 should be reconsidered.
71. Medical scheme membership is voluntary, and should an individual elect to purchase medical cover from a medical scheme that will fund a particular service, this would not mean that there is a duplication of costs with the NHI Fund, as the individual concerned would not be obtaining the services at the expense of the Fund, but rather at the expense of the medical scheme to which he/she is contributing.
72. To prohibit certain benefits being covered by medical schemes would actually place an increased burden on the NHI Fund.
73. In terms of section 27(1) of the Constitution, everyone has, amongst others, the right of access to healthcare. We submit that, should any person wish to access healthcare, they should not be limited in so doing. Should the amendment contained in section 34(3) be passed, it will have the effect that the persons choosing to access healthcare through their medical scheme will have this right of access limited.

74. The criteria set out in section 36 of the Constitution relating to the limitation of rights are not, in our view met by the amendments proposed in this section. The limitation of the medical scheme member's right of access to healthcare via their medical scheme is neither reasonable nor justifiable.
75. The intention expressed in the Draft NHI Bill is that the NHI will operate on a mandatory pre-payment system. Medical scheme members will, in terms of this, be contributing to the NHI Fund in addition to paying for their medical scheme cover. The "duplication of costs", referred to in section 34(3) does not, in any way, have an impact on the monies received by the NHI Fund. It is the individual's choice to obtain additional coverage at their own expense. There is thus no rational, legal or financial reason to limit the benefits offered by medical schemes in the event that those benefits are also available under the NHI.

Inspection and Information from Non-Registered Entities

76. Section 44(1) is proposed to be amended to give the Registrar the power to require from a scheme or any person accredited in terms of the MSA or transacting any business with a medical scheme to produce "its books, documents, records and financial statements" as part of an inspection or investigation. As healthcare providers transact business with a medical scheme, they would foreseeably be required to make available their records and financial statements to the Registrar during the course of the investigation. It is our submission that unfettered power of the Registrar should be curtailed in respect of having access to the financial statements and records of healthcare providers. This section grants the Registrar similar search and seizure powers to an Anton Pillar order, without the necessity of having to obtain such a court order. It is therefore submitted that his amendment is unacceptable and must be revised.
77. Under subsection (7) the Registrar may require the scheme to provide for a report by an actuary. The basis of an inspection can now, under section 44(9), not only take place on the financial soundness of a scheme, but also in the interest of the members of the scheme. It is unclear how these powers will be exercised, and how the Registrar will determine what is in the interest of the members of the scheme.
78. Subsection (8), relating to the Registrar's powers to place restrictions on a medical scheme's non-healthcare expenditure, is a welcome insertion.
79. Section 45 is about requiring information from entities not registered at the CMS, to the registrar. The proposed amendments add more powers, namely that after receiving the information, the Registrar may inform that entity they are operating in contravention of the

MSA and direct them to cease their business. This section does not, however, provide for an enforcement process for the situations where the business disregards the Registrar's instruction to cease operations.

Complaints and Disputes

80. The process of lodging of complaints and disputes with the CMS is drastically revised in this Draft MSA Bill. The Registrar is directed to publish guidelines for dispute resolution mechanisms that must be included in the medical scheme rules. This will hopefully reduce the backlog that the CMS presently experiences in dealing with complaints. The scheme member must first address their complaint to the medical scheme and follow the scheme dispute resolution process.
81. The amendments to the lodging of complaints are therefore generally welcomed. However, we note that in terms of section 47(4)(b)(iii), a person may complain to the Registrar about a person whose professional activities are regulated by the MSA, where such person has treated a member unfairly. We submit that where a member has been treated unfairly by a practitioner (whose activities are also to some extent regulated by the MSA), the member must lay a complaint with the practitioner's registration body, not the Registrar of medical schemes.
82. The current section 48 of the MSA (Appeal to Council) is to be repealed. This simplifies the Appeals process and is a welcome amendment.
83. Section 49 is amended to become the only avenue for appeals against the decisions of the Registrar. The appeal no longer suspends the operation of the decision of the Registrar. It is submitted that the Draft MSA Bill should make provision for strict timelines in respect of finalising appeals in order to avoid matters that become unduly protracted. It is further submitted that an expedited appeals process be included for urgent matters.
84. Section 50 makes provision for the establishment and constitution of members of the Appeal Board who are all appointed by the Minister. This appointment is not accompanied by a consultation process and therefore the Minister alone determines who shall be on the Appeal Board. It would be preferable for the Minister to consult with the CMS prior to appointing Appeal Board members. There is no provision in this new section 50 for the process of electing or appointing the chairperson. The only prescription is that the chairperson must be an advocate, attorney or a former judge. We submit that a process for the election or nomination as chairperson of the Appeal Board should be included in this section.
85. Section 50A empowers the chairperson of the Appeal Board to appoint members of the Appeal Board to the appeals panel. Section 50A(1)(e) allows the chairperson to publish rules for appeals

proceedings in the Government Gazette. The provisions contained in the proposed section 50A regarding the Appeals process and proceedings are extensive and proscriptive. They govern each aspect of the appeal and, as such, clarity is sought on what rules the Appeal Chairperson would be authorised to publish, bearing in mind that no Notice may contain provisions that are in conflict with the enabling legislation.

86. Section 50A provides that the appeal matters will be decided on the papers, although provision is made for oral evidence to be heard if an application from a party to the proceedings in this regard is granted. This limitation may expedite proceedings in terms of time and cost, but will limit the parties from providing explanations and context to the dispute. The Appeal Board can now also refer a matter to the Registrar for re-consideration. It is unclear how this aligns with the principle of the Registrar being *functus officio*, by already having made a pronouncement on the matter.
87. The amendments empowering the Appeal Board to make cost orders, and the making public of the Appeal Board decisions are welcomed.

Governance of Medical Schemes

88. In general, the new sections 56A to 56O are welcomed. There may be aspects where the corporate governance provisions can be strengthened even more. Specific obligations should be placed on trustees, CEOs and their governance structures, to align with practical challenges in, for example, managed care contracting, and the evaluation of such services rendered by administrators and others.
89. It is submitted that reference to the duty of the board of trustees of schemes to ensure compliance with the MSA and all applicable law should be included in the wording of section 56.

Self-Administered Schemes

90. The implication of the wording of section 58A is that the standard for the administration of a medical scheme by an administrator will differ from the standards, to be determined by the CMS, applicable to a self-administered scheme. The reasoning for this distinction is unclear as it would be appropriate for the standards of administration to, be uniform regardless of whether such administration is done by the scheme or by an administrator.

Regulations

91. Section 67 is amended to include that provision is made for regulations required by the amendments contained in this Draft MSA Bill. It is our submission that where the Registrar, or the CMS, are authorised, in terms of the proposed amendments, to issue directives by means of publishing a Notice in the Government Gazette, these provisions should instead require the publication of Regulations and therefore be included in this section.

General Comments and Observations

92. The amendments proposed by the Draft MSA Bill are generally to be welcomed, particularly in relation to the improved governance of medical schemes and the simplification of the complaints and appeals processes.
93. The Draft MSA Bill must be reviewed for typographical errors and correct use of grammar to ensure the consistent interpretation thereof.
94. There are a number of undefined terms introduced in the Draft MSA Bill, for example "*comprehensive service benefits*," "*comprehensive service benefits conditions*" or "*service benefits*." For the proper interpretation of the proposed amendments and reading of the MSA, these terms should be defined.
95. It is unfortunate that the Draft MSA Bill has not taken into account the recommendations of the HMI which would have been helpful in ensuring improved sustainability and viability of medical schemes in the current and future environment. The Competition Commission embarked upon an extremely lengthy and costly Health Market Inquiry. The Provisional Findings and Recommendations Report was published on 5 July 2018. It is regrettable that the drafters of this Bill have, in haste, appeared to disregard these findings and recommendations in their entirety. The report is based on the consideration and evaluation of extensive submission and public hearings of all stakeholders in the private healthcare industry, as well the public sector. It is our contention that failure to incorporate the recommendations of the Health Market Inquiry as well as the industry comments on these recommendations into this Bill is ill-advised and would render the Health Market Inquiry as an exercise in futility. It is therefore our strong recommendation that due consideration be given by the drafters to the HMI Report and industry inputs and incorporate same into a new raft of this Bill.
96. As mentioned above, the Draft MSA Bill proposes a drastic increase in the Registrar's powers. These powers, in some instances are transferred away from the Council and now vest in one person. The proposed section 33 allows the Registrar to approve and withdraw benefit options

based on his/her evaluation of the financial impact and the best interests of beneficiaries. Currently, the MSA provides the Council must be involved in such decision-making process. Other increased powers are the search and seizure provisions contained in in the proposed section 44(1), referred to above and the authority to personally amend a medical scheme's rules in terms of section 31(4). We submit that such unfettered control being vested in one individual, appointed by the Minister, is not acceptable.

97. Furthermore, the new proposed complaints and appeals process does not allow for a suspension of the operation of the decision of the Registrar, pending the outcome of the particular appeal. The delay in reversing an incorrect decision of the Registrar pending the outcome of the appeal process may have a significant impact on either the medical scheme or any complainant in the matter. Our submission, therefore is that the provisions relating to the extended individual powers of the Registrar be redrafted to increase accountability and the involvement of the Council so as to limit the possibility of unilateral and arbitrary decisions, which would invariably result in protracted litigation.
98. The introduction of the Comprehensive Service Benefits regrettably lacks substance in the Draft MSA Bill and there remains a lack of clarity in respect of how this system will operate as an apparent replacement to the current Prescribed Minimum Benefits.
99. The integration of the functions of the CMS within the NHI environment also requires clarification.
100. We trust our comments and suggestions are of assistance and look forward to future engagement on these critically important issues.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Chris Amey". The signature is fluid and cursive, with a long horizontal stroke extending from the bottom of the name.

Chief Executive Officer