NATIONAL HEALTH INSURANCE BILL, 2022

Arrangement of Sections

Section

NATIONAL HEALTH INSURANCE BILL, 2022

A BILL FOR AN ACT TO REPEAL AND REPLACE THE NATIONAL HEALTH INSURANCE ACT, 2016 TO PROVIDE FOR A MINIMUM STANDARD HEALTH BENEFIT AND FOR CONNECTED PURPOSES

Enacted by the Parliament of The Bahamas

PART I - PRELIMINARY

1. Short title and commencement.

(1) This Act may be cited as the National Health Insurance Act, 2022.

(2) This Act shall come into force on a date to be appointed by the Minister by notice published in the Gazette and different dates may be appointed by notice for the coming into force of particular sections or any Part of the Act.

2. Interpretation.

In this Act —

"actively enrolled" has the meaning specified in section 22(1)(a);

"actuary" means a person who is in good standing of a professional body of actuaries that is internationally recognized;

"approved insurer" means an insurer approved to carry on business in accordance with section 32;

"Authority" means the National Health Insurance Authority continued under section 4;

"benefits" means the goods and services provided to beneficiaries under the Plan or to insured persons by an approved insurer;

"Board" means the governing body of the Authority as constituted under section 4;

"contract of insurance" means a contract of insurance to provide for health coverage;

"enrolled" refers to the status whereby a person has been registered under the Plan and may or may not be actively receiving benefits through the Plan;

"inactively enrolled" has the meaning as specified in section 22(1)(b);

"Insurance Commission" means the Insurance Commission of The Bahamas established under section 4 of the Insurance Act (*Ch. 347*);

"insured person" means a person or group of persons (including an organization) for whom or for which coverage is provided by an approved insurer under the terms and conditions of a contract of health insurance;

"Minister" means the Minister charged with responsibility for national health insurance;

"National Health Insurance Fund" or **"the Fund"** means the National Health Insurance Fund established under section 10 of the repealed Act and continued under section 19;

"Plan" means the National Health Insurance Plan implemented under the repealed Act and continued under section 21;

"primary care provider" means a health care provider who provides the first level of health care that focuses on prevention, and addresses and coordinates all essential health needs for a beneficiary or insured person including referral to a specialist;

"primary health care" means the first level of health care that focuses on prevention, and addresses and coordinates all essential health needs including referrals to a specialist;

"Public Finance Management Act" means the Public Finance Management Act, 2021 (*No. 8 of 2021*);

"repealed Act" means the National Health Insurance Act, 2016 (*No. 29 of 2016*);

"standard health benefit" means the minimum scope of services provided by the Plan and approved insurers as specified in the *Third Schedule;*

"Standard Health Benefit Network" means the group of Standard Health Benefit Providers contracted by the Authority to deliver services;

"Standard Health Benefit Provider" or **"Provider"** means a person contracted by the Authority to deliver benefits under the Standard Health Benefit Network.

3. Objectives of Act.

The objectives of the Act are —

(a) to facilitate the provision of modern, affordable and accessible health care services to eligible and actively enrolled persons in the Plan;

(b) to establish a minimum standard of coverage of all health insurance plans; and

(c) to improve overall population health in The Bahamas.

PART II - NATIONAL HEALTH INSURANCE AUTHORITY

CONTINUATION, FUNCTIONS AND POWERS

4. Continuation of National Health Insurance Authority.

(1) The body corporate established under the repealed Act as the National Health Insurance Authority, is continued.

(2) The governing body of the Authority shall be a Board that performs the functions and exercises the powers of the Authority.

(3) The provisions of the *First Schedule* shall have effect as to the constitution and procedure of the Board and otherwise in relation thereto.

5. Seal of Authority.

The seal of the Authority —

(a) shall be kept in the custody of the Chairman or Deputy Chairman or such other person as the Board may direct;

(b) pursuant to a resolution of the Authority, may be affixed by the Secretary to the Board to instruments in the presence of the Chairman or a member of the Board designated by the Chairman and one other member of the Board;

(c) shall be authenticated by the signature of the Chairman or Deputy Chairman and the Secretary to the Board.

6. Functions of Authority.

The functions of the Authority are —

(a) to administer the National Health Insurance Plan in accordance with the Act;

(b) to provide benefits under the Plan and conduct periodic reviews thereof, to make modification to the scope of coverage, in consultation with the Minister of Health and the Minister of Finance;

(c) to establish a minimum standard of coverage;

(d) to establish and implement mechanisms for —

(i) quality assurance in the delivery of health care and services delivered under the standard health benefit;

(ii) the delivery of wellness services and initiatives;

(e) to promote improved methods and levels of efficiency in the delivery of health care and wellness benefits and services;

(f) to establish the criteria for registration of a Standard Health Benefit Provider under the Network;

(g) to enrol and categorize all persons eligible to receive benefits under the Plan in accordance with section 22;

(h) to maintain a register of all Standard Health Benefit Providers participating in the Plan and from time to time to publish an approved list of Standard Health Benefit Providers;

(i) to ensure appropriate coverage of providers and services delivered through the standard health benefit equitably across the islands of The Bahamas;

(j) oversee the Standard Health Benefit Network and to ensure quality standards and compliance with the terms of the agreement;

(k) manage, control and keep under constant review the Fund and supervise and control expenditures therefrom;

(l) produce an annual report outlining the Authority's impact on health insurance coverage and health service delivery;

(m) cause a review of the provisions of this Act to be conducted at least once every two years and publish a report with recommendations, if any, to the Minister;

(n) investigate any breach against any provision of this Act and to take such action that the Authority considers appropriate, or to refer the investigation to the Insurance Commission if the Authority deems necessary;

(o) do or cause to be done such other things as may be conferred by this Act or any other written law or that is considered necessary to enable the Authority to carry out its functions.

7. Powers of Authority.

(1) The Authority shall have power —

(a) to establish and cause amendments to be made to benefits provided under the Plan;

(b) to fix fee schedules and payment rates for Standard Health Benefit Providers;

(c) enter into agreements for provisions of the standard health benefit for both the Authority and approved insurers;

(d) to regulate the maximum price by approved insurers for benefits rendered under the standard health benefit;

(e) to utilize the monies in the Fund to deliver benefits under the Plan and to invest any available funds thereof;

(f) to appoint officers, employees and agents as the Authority considers necessary;

(g) to enter into written agreements with —

(i) entities for the administration of the Plan;

(ii) Standard Health Benefit Providers for the provision of benefits under the Plan;

(h) to conduct investigations and regular audits, and cause on-site inspections of Providers to be conducted in accordance with section 44;

(i) to require a person to produce information in accordance with section 8;

(j) to appoint committees constituting such number of persons as the Board thinks fit and such persons need not be members of the Board;

(k) to outsource any power or function upon terms and conditions to be agreed, except that where the expenditure to outsource is likely to exceed one per cent of the annual budget of the Fund, such outsourcing shall be subject to the approval of the Minister;

(l) to do or cause to be done, such other things as may be conferred by this Act or any other written law or that is deemed necessary to enable the Authority to carry out its functions.

(2) Subject to the provisions of this Act, any power or function which the Authority may exercise or perform under this Act may be delegated in writing to any member of the Board, committee appointed under this Act or an employee, subject to such terms, conditions or restrictions as the Board may determine and the Board shall not be divested of any power delegated by it.

(3) A committee appointed pursuant to subsection (1) shall regulate its own procedures.

8. Power of Authority to require information.

(1) In the performance of its duties under this Act, the Authority may at all reasonable times require —

(a) a Provider or approved insurer, to supply such information as the Authority may reasonably require, or to produce for examination such records that are required to be kept pursuant to section 42;

(b) a beneficiary to supply such information as the Authority may reasonably require for the purpose of enabling the Authority to perform its functions under this Act;

(c) a body specified in the *Second Schedule* to supply such information as the Authority may reasonably require to perform its functions under this Act.

(2) Any Provider or approved insurer who fails or refuses to produce any record or to supply any information as required by subsection (1) commits an offence.

(3) Any beneficiary or insured person who fails or refuses to produce any record or to supply any information as required by subsection (1) is liable to pay the full cost of any medical services rendered based on the national standardized fee and coding guide.

MANAGEMENT OF AUTHORITY

9. Appointment of Managing Director.

(1) There shall be a chief executive of the Authority appointed by the Board (hereinafter referred to as "the Managing Director") who shall —

(a) have responsibility for the day to day operations of the Authority; and

(b) perform such duties as are assigned by the Board or under any other written law.

(2) The Managing Director shall hold office on such terms and conditions as the Board may approve.

(3) The Board may employ such other officers, employees and agents at such remuneration and on such terms and conditions as it considers necessary or appropriate for the proper conduct of its business.

(4) The Managing Director, may, in writing, delegate to any employee of the Authority any of the responsibilities, powers or functions of the Managing Director, unless such delegation is prohibited by this Act.

10. Appointment and functions of Compliance Officer.

(1) The Board shall, in consultation with the Managing Director, appoint a compliance officer (hereinafter referred to as "the Compliance Officer") —

(a) to investigate any potential violation of this Act or any regulations made thereunder and to refer such violation to the respective regulator or body; and

(b) to educate relevant parties on their responsibilities under this Act.

(2) The Compliance Officer may —

(a) without notice during business hours, enter and have access to any premises, where he has reasonable grounds to believe that any book, paper, document, thing or electronically stored data are kept that relate to any matter associated with the potential violation of this Act;

(b) make investigations and inquiries, and take, remove, require and copy the production of any book, paper, document, thing or electronically stored data that relate to any matter under this Act or any regulations made hereunder;

(c) commence and determine disciplinary proceedings against Providers in relation to contraventions of this Act;

(d) refer any breach of this Act by an approved insurer to the Insurance Commission;

(e) recommend the termination of any Provider or primary care provider where there has been a violation of this Act;

(f) delegate his authority in writing to any other authorized person; and

(g) exercise such other powers as may be reasonably necessary.

11. Powers of Minister in the interest of public health.

(1) If a public health emergency is declared under any other written law, the Minister after consultation with the Authority may give such directives, whether of a general or specific character to address the public health emergency.

(2) In order to address the public health emergency, the Minister, in consultation with the Authority, may —

(a) by order, temporarily amend the *Third Schedule;*

(b) temporarily utilize the services of the Standard Health Benefit Provider Network.

(3) An order made pursuant to subsection (2) shall state the duration thereof and such order may be extended where the Minister considers it necessary in the public interest.

FINANCIAL PROVISIONS

12. Application of Public Finance Management Act and Public Debt Management Act.

(1) The relevant provisions of the Public Finance Management Act applicable to an agency, shall apply to the Authority with respect to —

(a) accounting standards;

(b) annual plans;

(c) reporting;

(d) public investments; and

(e) projects and borrowing.

(2) The relevant provisions of the Public Debt Management Act applicable to an agency, shall apply to the Authority with respect to —

(a) reporting liabilities; and

(b) borrowing.

(3) The Minister shall be responsible to the House of Assembly for the performance of the functions of the Minister specified in the Public Finance Management Act, including the requirement to oversee and direct the Authority in accordance with the provisions of the Public Finance Management Act to achieve objectives contained in the statement of corporate intent and business plan.

13. Funds and resources of the Authority.

The funds and resources of the Authority shall consist of —

(a) any monies as from time to time are provided by Parliament;

(b) any monies as from time to time accrue to the Authority from its operations;

(c) any monies as from time to time are borrowed by the Authority pursuant to section 15;

(d) any donations made to the Authority;

(e) any monies payable by an employer of an insured person for standard health benefit services rendered under this Act;

(f) any other monies and property as from time to time may in any manner be lawfully paid to or vested in the Authority.

14. Books and records of accounts to be kept.

(1) The Authority shall cause to be kept proper books and records of accounts of income, expenditure, assets and liabilities of the Authority in relation to its affairs.

(2) The books and records of accounts shall be audited annually by an independent auditor appointed by the Authority and licensed with The Bahamas Institute of Chartered Accountants.

(3) The Auditor-General shall, at any time, be entitled to inspect and audit the accounts and records of financial transactions of the Authority and records relating to assets of, or in the custody of, the Authority.

15. Borrowing powers.

(1) Subject to this section, the Authority may borrow sums required by it for meeting any of its obligations or discharging any of its functions and may in respect of such borrowing, issue debentures or other securities in such form as the Authority may determine.

(2) Any borrowing by the Authority pursuant to subsection (1) shall be approved by the Minister of Finance in consultation with the Minister.

16. Guarantee of loans to Authority.

The provisions of the Public Debt Management Act with respect to the giving of a guarantee in support of any authorised borrowing, shall apply to the Authority.

17. Reserve Fund.

(1) All monies of the National Health Insurance Fund not immediately required to be expended in meeting any of the obligations of the Authority or discharging any of its functions or the functions of other government agencies with responsibilities related to this Act shall be paid into a Reserve Fund as prescribed.

(2) The Authority may determine —

(a) the management of the Reserve Fund;

(b) use of the Reserve Fund; and

(c) the sums to be carried from time to time to the credit of the Reserve Fund, but no part of the Reserve Fund shall be applied otherwise than for the purposes of the objectives of this Act.

(3) The Minister may make regulations governing the Reserve Fund.

18. Power to invest.

(1) The Authority may, subject to the approval of the Minister of Finance, and to the provisions of the Public Debt Management Act, invest monies in —

(a) securities issued or guaranteed by the Government; and

(b) other securities, real estate, financial contracts, agreements and investments authorised by the Minister on the recommendation of the Authority.

(2) Notwithstanding subsection (1), the Authority shall not invest in property or securities outside The Bahamas without the general or special directions of the Minister, after the Minister has obtained the concurrence of the Minister responsible for finance and any other requisite regulatory approval under any other law.

(3) Any investment exercised other than pursuant to subsection (2), may be approved either generally or specifically by the Minister.

PART III - NATIONAL HEALTH INSURANCE FUND

19. Continuation of National Health Insurance Fund.

(1) The National Health Insurance Fund established under the repealed Act is continued for the purpose of financing the cost of health care services, products and benefits under the Plan.

(2) The Fund shall be under the control and management of the Authority.

20. Monies paid into or met out of Fund.

(1) There shall be paid into the Fund —

(a) such sums as are allocated to the Fund for the purposes of the Plan;

(b) such sums properly accruing to the Fund whether by way of loans, grants, donations, rent, dividends or investments;

(c) such other monies lawfully paid into, received by or made available to the Fund.

(2) There may be paid out of the Fund —

(a) the cost for health care services; products and benefits for beneficiaries under the Plan;

(b) any refund for payment received in error;

(c) the cost for any other necessary payments in respect of the Plan.

PART IV - NATIONAL HEALTH INSURANCE PLAN

21. Continuation of National Health Insurance Plan.

The National Health Insurance Plan implemented under the repealed Act is continued for the purposes of this Act, with such modifications as are provided for in accordance with the provisions of this Act.

ENROLMENT IN PLAN

22. Categories of enrolment under the Plan.

(1) For the purposes of this Act, there shall be two categories of enrolment under the Plan, namely, a person may be —

(a) actively enrolled, if he has applied for enrolment and —

(i) has met the criteria outlined in section 23 and does not fall within the category of persons specified in section 23(2)(a) (a) and (c);

(ii) has been assigned the status of actively enrolled under the Plan; and

(iii) is actively eligible to receive benefits under the Plan; or

(b) inactively enrolled, if he was actively enrolled in the Plan under the repealed Act or pursuant to paragraph (a) and has —

(i) since the date of his enrolment, acquired private health insurance or continues to hold private health insurance;

(ii) not accessed the benefits covered under the Standard Health Benefit within a reasonable period as determined by the Authority; or

(iii) expressed in writing that he no longer desires to be enrolled in the Plan.

(2) The Authority shall designate the category of enrolment in respect of every person enrolled under the Plan and shall notify each person of such.

(3) Where a person loses his private health insurance coverage due to loss of employment or otherwise, that person shall be assigned actively enrolled status immediately upon receipt of notice from an approved insurer of such loss of employment, unless such person notifies the Authority in writing forthwith stating his desire not to be enrolled.

23. Eligibility for enrolment in Plan.

(1) A person is eligible to enrol in the Plan if he —

(a) is —

(i) a citizen of The Bahamas and ordinarily resident in The Bahamas; or

(ii) a lawful resident of The Bahamas in accordance with the Immigration Act (*Ch. 191*), except for a person on a work permit of less than one hundred and twenty days or a dependent of a person on a work permit of less than one hundred and twenty days; and

(b) is registered with the National Insurance Board and possess a valid national insurance card.

(2) A person is not eligible to enrol in the Plan if he —

(a) is employed by an international organisation declared as such pursuant to section 3 of the International Organisations (Immunities and Privileges) Act (*Ch. 14*);

(b) fails to meet the criteria outlined in subsection (1); or

(c) possesses private health insurance coverage from an approved insurer for benefits covered under the standard health benefit.

(3) Notwithstanding any other law, for the purposes of subsection (1), "ordinarily resident" shall be construed to mean that a person's ordinary residence shall not be considered to have been interrupted by reason of the fact that the person is occasionally or temporarily absent from The Bahamas or is absent from The Bahamas because of that person's —

(a) occupation or employment, or that of his spouse or, if a minor, his parent or legal guardian, in the public service or at any embassy, high commission or any other agency of the Government of The Bahamas or any international organisation to which The Bahamas is accredited and that occupation or employment requires him, his spouse or, if a minor, his parent or legal guardian to travel outside of The Bahamas; or

(b) pursuit of a bona fide full-time programme of study, or such pursuit by his spouse, or, if a minor, his parent or legal guardian and such a programme involves occasional or regular residence outside of The Bahamas.

24. Persons enrolled under repealed Act.

(1) Any person who, at the date of the commencement of this Act, was enrolled in the Plan under the repealed Act, shall continue to be enrolled in the Plan for the purposes of this Act.

(2) Notwithstanding subsection (1), any person who possesses private health insurance shall be assigned the status of inactively enrolled.

25. Application for enrolment in the Plan.

A person who is —

(a) eligible to enrol in the Plan in accordance with section 23; and

(b) desirous of being actively enrolled in the Plan,

shall make application to the Authority in the prescribed manner.

26. Modification of enrolment status.

(1) A person who has been enrolled in the Plan and is desirous of changing his status from —

(a) inactively enrolled to actively enrolled;

(b) actively enrolled to inactively enrolled,

shall make application in the manner prescribed.

(2) Subject to the conditions as specified in section 22, the Authority shall approve the application and notify the applicant of its decision within ten days thereof.

27. Grounds for dis-enrolment from the Plan.

In the event of —

(a) the death of a person enrolled in the Plan;

(b) a change in citizenship or residency status of a person enrolled in the Plan;

(c) a recommendation by the Compliance Officer on justifiable grounds, for the dis-enrolment of a person from the Plan; or

(d) receipt of a written request by the Authority from a person enrolled in the Plan, to be dis-enrolled from the Plan,

the Authority shall dis-enrol the person from the Plan.

BENEFITS AND BENEFICIARIES

28. Eligibility and entitlement to benefits under the Plan.

(1) A person who is —

(a) actively enrolled in the Plan, shall be entitled to receive benefits under the Plan (hereinafter referred to as “a beneficiary”);

(b) inactively enrolled in the Plan, or dis-enrolled from the Plan, shall not be entitled to receive benefits under the Plan.

(2) Every beneficiary is entitled to receive the standard health benefit.

29. Beneficiaries to select a Standard Health Benefit Provider.

(1) Upon enrolment in the Plan, every beneficiary or legal guardian of a beneficiary must select a primary care provider from the list of Standard Health Benefit Network published by the Authority from time to time in such manner as the Authority may determine.

(2) A beneficiary may, once in each year and in the manner approved by the Authority, change his primary care provider.

(3) Notwithstanding subsection (2), where a beneficiary —

(a) has relocated to another settlement or island which makes it no longer feasible for the beneficiary to access his Provider;

(b) with good reason is not satisfied with the services of his Provider,

he may request a change of his Provider in the manner approved by the Authority.

30. Obligations of beneficiaries.

(1) Every beneficiary shall notify the Authority within thirty days thereof of any change in —

(a) his citizenship or residency;

(b) any other information that would impact his eligibility to receive benefits under the Plan.

(2) A beneficiary who fails to comply with subsection (1) commits an offence.

31. Termination, etc. of beneficiary status.

(1) The Authority may terminate or suspend the benefits of a beneficiary under the Plan where in the opinion of the Authority the beneficiary —

(a) is no longer eligible to be enrolled under the Plan in accordance with the Act;

(b) has failed to comply with the provisions of section 29(1);

(c) is committing or has committed a fraud under this Act.

(2) Where the benefits of a beneficiary are terminated or suspended under subsection (1), the beneficiary will be eligible to appeal the decision in accordance with section 48.

APPROVED INSURERS

32. Approved insurers for purposes of Act.

Every insurer registered to carry on medical health insurance plans, under the Insurance Act (*Ch. 347*) shall pursuant to section 206A of the Insurance Act, be deemed to be an approved insurer for the purposes of this Act and shall enter into an agreement with the Authority providing for the matters outlined in section 33.

33. Provisions of agreement with Authority.

An agreement referred to in section 32 shall provide for —

(a) data sharing with respect to beneficiaries in accordance with the Data Protection (Privacy of Personal Information) Act (*Ch. 324A*);

(b) access to information, not limited to the name, date of birth and national insurance number of insured persons;

(c) the terms of the standard health benefit in a contract of insurance;

(d) the selection of a primary care provider within the Standard Health Benefit Network by insured persons;

(e) the provisions in a contract of insurance with respect to —

(i) the procedure for access of services by beneficiaries, including the referral process;

(ii) the benefits for insured persons and the payment rates for such benefits;

(iii) the procedure for the processing and management of claims;

(iv) terms of payment for services rendered;

(v) co-payments or deductibles for services;

(vi) financial and clinical audit functions to be conducted;

(vii) the general responsibilities of the parties;

(viii) automatic enrolment in the Plan in the event an insured person loses coverage; and

(f) such other matters deemed necessary to carry out the objectives of this Act.

34. Duties of approved insurers.

It shall be the duty of every approved insurer —

(a) to provide the standard health benefit coverage to all insured persons in accordance with section 206A of the Insurance Act (*Ch. 347*);

(b) to cooperate with the Authority to identify those insured persons whose coverage has or will expire, to enable the Authority to independently enrol such persons in the Plan;

(c) to provide proof of insurance within two weeks of the issuance of a contract of insurance to an insured person;

(d) to provide insured persons at the time of the execution of a contract of insurance, and every year thereafter, with a list of Providers under the Standard Health Benefit Network for the purposes of —

(i) selecting a Provider, or;

(ii) opting out of the selection of a Provider, given that the approved insurer has notified such persons of the impacts, financial and otherwise, of making this choice;

(e) to submit such information in relation to a contract of insurance as may be requested from the Authority; and

(f) to do, or cause to be done, such other things as are necessary or expedient for or in connection with carrying out the objectives of this Act.

35. Authority may recommend action to be taken against an approved insurer.

(1) Where an approved insurer commits any act specified in paragraphs (a) – (h), the Authority may recommend to the Insurance Commission to issue an administrative sanction or fine or to suspend or cancel the registration of the approved insurer under the Insurance Act —

(a) commits any act of fraud in relation to the Standard Health Benefit Network;

(b) fails to disclose any material information requested by the Authority;

(c) fails to comply with any recommendation of the Compliance Officer pursuant to section 10(3);

(d) discloses or fails to protect confidential data;

(e) without reasonable cause, fails to provide appropriate benefits to an insured person;

(f) commits any act or omission that results in the revocation or suspension of the approved insurer's licence pursuant to the Insurance Act;

(g) breaches any material term of an agreement entered between the approved insurer and the Authority; or

(h) contravenes any obligation under this Act.

(2) For the avoidance of doubt, the Insurance Commission shall not require a referral from the Authority to penalize an approved insurer for contravening this Act but shall be required to investigate any referral made thereto.

36. Liability of approved insurers.

An approved insurer shall not be relieved of any liability in respect of a contract of insurance in force at the date of this Act if —

(a) the registration of the approved insurer is cancelled or suspended for any reason under the Insurance Act (*Ch. 347)*;

(b) the approved insurer withdraws from the business of providing health insurance; or

(c) the activities of the approved insurer have been restricted for any reason under the Insurance Act.

STANDARD HEALTH BENEFIT PROVIDERS

37. Eligibility of Standard Health Benefit Providers.

Upon application in writing and payment of the prescribed fee, any person who satisfies —

(a) the Authority that it has met the requirements of any law governing the health profession and practice of that person; and

(b) such other requirements as may be determined by the Authority,

may be approved by the Authority to participate as a Standard Health Benefit Provider under the Standard Health Benefit Network (hereinafter referred to as "a Provider").

38. Provider to enter into agreement with Authority.

(1) A person approved under section 37 shall enter into an agreement with the Authority providing for —

(a) the standards and conditions for participation in the Standard Health Benefit Network;

(b) the procedure to access services by beneficiaries or insured persons, including the referral process;

(c) benefits to be provided under the Plan;

(d) fee schedules and payments rates for provision of benefits under the Plan;

(e) the terms of payment for services rendered;

(f) health care quality assurance and standards of care;

(g) the procedure for the submission of claims;

(h) on-site, financial and clinical audit functions to be conducted;

(i) access to benefits by beneficiaries or insured persons;

(j) reporting requirements;

(k) the use of electronic reporting of health records;

(l) the use of a standard claims submission process;

(m) the general responsibilities of the parties;

(n) any necessary data sharing in accordance with the Data Protection (Privacy of Personal Information) Act (*Ch. 324A*); and

(o) such other matters deemed necessary to carry out the objectives of this Act

(2) The Authority shall keep a register of all Providers entering into an agreement with the Authority pursuant to subsection (1).

39. Provisional registration of Providers.

(1) The Authority may grant provisional registration in respect of a person who fails to meet the requirements specified in sections 37, where in the opinion of the Authority, the person has the ability to meet the requirements of this Act within a reasonable time period specified in a provisional agreement.

(2) If a provisionally registered Provider fails to meet the requirements of the Authority within the time period specified in the provisional agreement, the Authority may at its discretion grant a temporary extension.

40. Functions of Providers.

The functions of a Provider are —

(a) to provide applicable benefits under the Plan to beneficiaries;

(b) to provide to the Authority or an approved insurer such information as may be required;

(c) to record beneficiary health information in an electronic health record provided by the Authority;

(d) to submit reports of service and claims electronically to the Authority or the approved insurer; and

(e) to carry out such other functions as may be provided for in the agreement.

41. Quality of care by Providers.

The Authority may develop relevant guidelines, protocols, policies or procedures specifying the quality of care to be maintained and implemented by Providers under the standard health benefit, to assure quality of care, appropriate utilisation of benefits and technology usage to ensure that —

(a) a high quality of health care services delivery;

(b) access to benefits is suitable, equitable and standardized;

(c) the use of medical technology and equipment is consistent with the needs and standards of medical practice;

(d) benefits are appropriate, necessary and comply with accepted medical practice and ethics; and

(e) electronic health records are used consistently and appropriately.

42. Providers to keep and maintain records.

(1) Every Provider shall in a manner determined by the Authority, maintain and keep records relating to —

(a) the benefits rendered under the standard health benefit;

(b) all claims under the standard health benefit, where applicable;

(c) financial records related to the standard health benefit;

(d) the performance standards as required by the Authority;

(e) all past and current patients and their enrolment status; and

(f) such other information as the Authority or approved insurer may require.

(2) Every Provider shall upon written request, for the purpose of investigating any contravention of any provision of this Act, provide the Authority with access to electronic records relating to the care of any person or matter in question.

43. Duty to submit reports.

Every Provider shall submit a report to the Authority in the manner and form determined by the Authority and in accordance with the Data Protection (Privacy of Personal Information) Act (*Ch. 324A*), with respect to the services of the Provider, and the beneficiary or insured person's health outcomes and satisfaction reports and such a report shall contain details on —

(a) names of insured persons, beneficiaries or both;

(b) the national insurance number of insured persons, beneficiaries or both;

(c) date of birth, sex and other demographic information of insured persons, beneficiaries or both;

(d) financial data;

(e) utilization data;

(f) beneficiary or insured persons' health outcome data;

(g) beneficiary, insured persons' and Provider satisfaction survey data;

(h) specific quality and performance data; and

(i) such other data as may be considered necessary by the Authority.

44. Inspection of Providers.

(1) The Authority is empowered to —

(a) inspect the premises, equipment, procedures and information technology systems of a Provider and any documents related thereto;

(b) examine the claims, data and accounting records in the possession of a Provider;

(c) make such enquiries as may be necessary to ascertain whether the provisions of this Act are being or have been complied with in any such premises or place of the Provider.

(2) The representative of the Authority acting pursuant to subsection (1) —

(a) shall produce evidence of his authority to act on behalf of the Authority;

(b) shall complete an inspection report and make recommendations with respect to the Provider and such recommendations shall be forwarded to the Provider; and

(c) may request the assistance of a peace officer in carrying out his functions.

45. Termination of Providers.

The Authority may in the interest of public health or safety, or on the basis of any of the following grounds, terminate the participation of a Provider if the Provider —

(a) submits a false or fraudulent claim;

(b) commits any act of fraud in relation to the standard health benefit;

(c) fails to disclose any material information requested by the Authority;

(d) fails to utilize electronic health records;

(e) fails to comply with any recommendation of the Compliance Officer or an authorized person acting on behalf thereof pursuant to section 10;

(f) discloses confidential data or fails to protect confidential data;

(g) fails to meet any quality assurance or minimum standards of care;

(h) fails to provide benefits to beneficiaries without good cause;

(i) does any act or omission that results in the revocation or suspension of his licence under any other law;

(j) breaches any material term of the agreement entered into pursuant to section 38; and

(k) fails to satisfy the requirements specified in section 37.

PART V – MISCELLANEOUS

46. Minister may amend Second and Third Schedules.

The Minister may, by order amend —

(a) the *Second Schedule;*

(b) from time to time, the *Third Schedule,* on the recommendation of the Authority.

47. Withdrawal of Providers.

(1) Any Provider that no longer wishes to participate in the Standard Health Benefit Network shall —

(a) provide the Authority with no less than ninety days written notice of the intention to withdraw participation; and

(b) assist with the transition of care of beneficiaries;

(c) no longer eligible as a Provider under the Standard Health Benefit Network,

and any beneficiary of that provider shall no longer be entitled to receive benefits under the Plan with that Provider.

(2) Any Provider that fails to satisfy the requirements of subsection (1), commits an offence.

48. Rights of appeal to determine grievances.

Where a person is —

(a) denied enrolment under the Plan;

(b) aggrieved in respect of any violation of his entitlement under the Plan; or

(c) aggrieved by any decision of the Authority,

he may appeal the decision to a tribunal of not less than two persons constituted by the Minister and the decision of the tribunal shall be final.

49. Cooperation and information sharing.

(1) The Authority may cooperate with any government agency, including the sharing of information, that it has acquired in the course of its duties or in the exercise of its functions under this or any other law where the Authority—

(a) considers that such cooperation or information may be relevant to the discharge of the statutory functions of the requesting agency; and

(b) the requesting agency has a reciprocal arrangement in place to facilitate a request from the Authority for information that may be relevant to the discharge of its statutory functions.

(2) The National Insurance Board shall in a timely manner provide the Authority with such access to relevant data as required by the Authority to validate the eligibility of beneficiaries and to otherwise perform its duties under this Act.

(3) The Insurance Commission shall upon request, provide the Authority with such regulatory information as is necessary to enable the Authority to validate the conduct of approved insurers and otherwise perform its functions under this Act.

(4) Notwithstanding the provisions of this section, the Authority shall not share any confidential information concerning the medical history of a beneficiary.

(5) Subsection (4) shall not apply to a disclosure of information —

(a) lawfully required or permitted by any court of competent jurisdiction within The Bahamas;

(b) in respect of the affairs of a beneficiary where the consent of the beneficiary or legal guardian, as the case may be, has been given voluntarily;

(c) where the information disclosed is in a manner that does not enable the identity of any beneficiary, approved insurer, or Provider to which the information relates to be ascertained.

(6) Any information shared pursuant to this section must be shared securely and in accordance with the Data Protection (Privacy of Personal Information) Act (*Ch. 324A*) and any regulations made thereunder.

(7) For the purposes of this section, the Authority may enter into an information sharing agreement with applicable parties.

50. Confidentiality.

(1) Any person who comes into contact with any data or information in carrying out his functions of this Act, relating to the affairs of —

(a) the Authority;

(b) a beneficiary or insured person; or

(c) a Provider or approved insurer,

shall —

(i) treat the data and information as secret and confidential;

(ii) not disclose such data or information without proper authorisation; and

(iii) take appropriate security measures to maintain the confidentiality of the data and information and to prevent unauthorised access to it, or its alteration, disclosure or destruction and to protect it against accidental loss or destruction.

(2) Subsection (1) shall not apply to a disclosure of data or information —

(a) lawfully required or permitted by any court of competent jurisdiction within The Bahamas;

(b) for the purpose of assisting the Authority to exercise any function conferred on it by this Act, or any other Act or regulations made thereunder;

(c) in respect of the affairs of a beneficiary or insured persons where the consent of the beneficiary, insured person, or legal guardian, as the case may be, has been voluntarily given;

(d) if the information disclosed is or has been available to the public from a lawful source;

(e) if the information disclosed pertains to the person making the disclosure; or

(f) if the information is disclosed in a manner that does not enable the identity of any beneficiary, insured persons Provider or approved insurer to which the information relates to be ascertained.

(3) Any person who contravenes this section commits an offence.

51. General offences.

(1) A person commits an offence if he —

(a) knowingly obtains any benefits under this Act by means of a false declaration;

(b) knowingly makes any false declaration or false statement of a material nature in any application made under this Act;

(c) wilfully attempts to use or uses funds paid or received with respect to this Act for purposes other than those authorised under the Act;

(d) agrees to any arrangement for the purpose of avoiding obligations under this Act;

(e) wilfully delays, assaults or obstructs the Compliance Officer or an agent thereof in the exercise of his functions under this Act;

(f) knowingly and intentionally commits fraud with respect to this Act;

(g) wilfully fails to pay any contribution or premiums under this Act;

(h) having received monies in advance for benefits, and without good reason fails to render services pursuant to any agreement;

(i) without lawful excuse, refuses to furnish any information or to produce any document when required to do so;

(j) wilfully fails to comply with any requirement or duty imposed upon him under this Act.

(2) A person who commits an offence specified in subsection (1) except for the offence specified in paragraph (f), shall be liable to a penalty as stipulated in section 52.

(3) A person who commits an offence under subsection (1)(f) shall be liable on summary conviction to a fine not exceeding two hundred and fifty thousand dollars.

52. General penalty.

(1) Where a person commits an offence against this Act for which no other penalty is specified, he is liable on summary conviction —

(a) in the case of a Provider, to a fine not exceeding ten thousand dollars and where the offence is a continuing offence, to a further fine of one thousand dollars for every day during which the offence continues;

(b) in the case of a beneficiary, to a fine not exceeding five thousand dollars, and where the offence is a continuing offence, to a further fine of five hundred dollars for every day during which the offence continues.

(2) In the case of an approved insurer, the Insurance Commission may take such action as is provided for in respect of a breach under the Insurance Act.

53. Non-derogation.

(1) For the avoidance of doubt, unless otherwise provided for in any other law, nothing in this Act shall derogate from —

(a) the provisions relating to any injury attracting industrial benefit under the National Insurance Act (*Ch. 350*) unless the extent of such care is provided under the *Third Schedule*;

(b) any bodily injury caused to any person arising out of the use of a vehicle on a road attracting coverage under a policy of insurance as required under the Road Traffic Act (*Ch. 220*);

(c) any collective agreement or existing employment contract providing health insurance greater than those established by the standard health benefit;

(d) any other law conferring a health care benefit on a person.

(2) For the purposes of subsection (1)(a), the Authority may enter into a cost sharing agreement.

54. Annual Report.

(1) The Authority shall, within six months of the end of each financial year, cause to be made and submit to the Minister an annual report.

(2) The annual report shall —

(a) include a copy of the statement of accounts certified by an auditor in respect of the Fund for that financial year;

(b) include a plan of the proposed objectives for the forthcoming year;

(c) set out the priorities of the Authority for the succeeding two years;

(d) set out the key performance indicators for the forthcoming year;

(e) set out the key activities carried out during the previous financial year; and

(f) set out the budget of the Authority establishing the target activities of the forthcoming year;

(3) The Minister shall cause a copy of the annual report together with the annual statement of accounts, the auditor's report and any actuarial report to be laid before each House of Parliament.

(4) The Authority shall take all necessary measures to make available to the public copies of the annual report, including by publishing the Report on its website, within thirty days after the same has been laid in Parliament.

55. Review of Act.

(1) This Act shall be reviewed from time to time by a committee of both Houses of Parliament appointed by the Prime Minister in consultation with the Leader of the Opposition.

(2) The first review of this Act shall be conducted not later than five years after the date of the first appointed day notice under the Act.

56. Regulations.

The Minister may, on the recommendation of the Authority, make regulations generally for the better carrying out of the provisions and objectives of the Act and, without prejudice to the generality of the aforesaid, the Minister may make regulations prescribing —

(a) the procedure for enrolment and dis-enrolment and selection of primary care providers by beneficiaries and insured persons;

(b) the categories of beneficiaries and insured persons and the applicable benefits relating thereto;

(c) the manner for modification of enrolment status;

(d) the registration criteria for Providers participating in the Standard Health Benefit Network;

(e) the procedure for the filing and determination of questions and grievances pursuant to section 48;

(f) the details of the scope of services provided under the standard health benefit as specified in the *Third Schedule*;

(g) matters related to information sharing, maintenance of records, privacy and data protection;

(h) matters relating to the setting of payments for Providers;

(i) the manner and form of any forms to be used;

(j) the reporting of data by Providers and approved insurers, and the form and manner thereof;

(k) the restrictions on which an insured person may opt-out of the standard health benefit network;

(l) any other matter required to be prescribed under this Act or required generally for the better carrying out of the objectives of the Act.

57. Savings.

On the date of the commencement of this Act —

(a) the person who immediately before the coming into force of this Act was the Managing Director under the repealed Act continues to be the Managing Director under and for the purposes of this Act as if that person had been appointed under this Act on the same terms and conditions for the term expiring on the day on which the appointment of the person would have expired under the repealed Act;

(b) all persons who were employed immediately before the coming in to force of this Act, continue to be employed by the Authority on the same terms and conditions;

(c) every person who immediately before the coming into force of this Act was a member of the Board of the Authority under the repealed Act continues to be a member of the Board under and for the purposes of this Act as if such person had been appointed under this Act, on the same terms and conditions for the term expiring on the day on which the appointment of such person would have expired under the repealed Act;

(d) every agreement, whether in writing or not, to which the Authority was a party or which affected the Authority, continues to have effect after the date of commencement, unless another agreement has been entered into otherwise by the respective parties.

58. Transitional provisions.

(1) Any person who, was registered as a health care provider under the repealed Act, immediately before the commencement of this Act, shall continue to be so registered, except that such person must —

(a) enter into an agreement with the Authority pursuant to section 38 and;

(b) meets the provisions of this Act and any regulations made thereunder.

(2) Where a document refers expressly or by implication to the repealed Act, the reference shall (except where the context otherwise requires) be construed as a reference to the corresponding provision of this Act.

59. Repeal and consequential amendments.

(1) The National Health Insurance Act, 2016 (*No. 29 of 2016*) is hereby repealed.

(2) The laws mentioned in the first column of the *Fourth Schedule* are amended to the extent specified in the second column of that Schedule.

FIRST SCHEDULE

(section 4(3))

CONSTITUTION AND PROCEDURES OF THE BOARD

1. Constitution of Board.

(1) The Board shall consist of eleven members —

(a) seven of whom shall be appointed by the Minister in his discretion of whom —

(i) one shall be regarded as having demonstrated experience in the health sector in areas including health service delivery, health workforce, health information systems, access to essential medicines, health financing, health leadership or governance,

(ii) one shall be regarded as having demonstrated experience in the commercial sector in areas including financial expertise, legal expertise, business strategy, business administration or executive-level management;

(iii) two shall be selected from among those categories of persons regarded as representative of the views of patients, Beneficiaries or civil society; and

(iv) one shall be selected from among those categories of persons regarded as representative of the views of the nursing or allied health professions;

(b) four of whom shall be approved by the Minister of whom —

(i) one shall be proposed by The Bahamas Chamber of Commerce and Employers Confederation;

(ii) one shall be proposed by the National Congress of Trade Unions Bahamas;

(iii) one shall be proposed by The Bahamas Insurance Association;

(iv) one shall be proposed from among the Medical Association of The Bahamas,

and not less than forty percent of the members of the Board shall be female and not less than forty percent shall be male.

(2) The Managing Director of the National Health Insurance Authority, the Chief Medical Officer, the Director of the National Insurance Board, the Superintendent of the Insurance Commission of The Bahamas and the Director of Social Services shall be ex-officio members with no voting rights.

(3) The Minister shall appoint the Chairman and the Deputy Chairman from among the appointed members of the Board.

(4) Prior to the acceptance of membership of the Board, a proposed member shall disclose whether or not he is a director or officer or shareholder of any business that offers a service in accordance with the Plan, and if the Minister is fully satisfied, upon completing due diligence with respect to the proposed member that the presence of the member shall not —

(a) prejudice the principles of natural justice; and

(b) subject the proceedings of the Board to a charge of bias, the Minister may proceed to issue a letter of appointment to that member.

(5) Upon appointment, or in any other case, before discharging any duty in connection to the Board, each member shall sign a declaration of acceptance of membership of the Board and an undertaking that he will adhere to the rules pertaining to his duties or any other such relevant rules or procedures.

2. Appointment of secretary.

There shall be a secretary to the Board who shall be appointed by the Board and who shall perform such functions at such remuneration and upon such terms and conditions as the Board may determine.

3. Tenure of members of the Board.

(1) All members of the Board, other than the ex-officio members shall hold office for a period not exceeding three years as specified in the instrument of appointment and may be eligible for re-appointment for an additional period not exceeding three years, but in any event must not hold office for more than two consecutive terms.

(2) Four members of the Board shall serve for an initial term of two years and five members of the Board shall serve for a term of three years.

(3) An appointed member may at any time resign his office by notifying the Chairman in writing who shall forward the same to the Minister and upon the date of the receipt by the Chairman of such document such member shall cease to be a member.

(4) The Chairman may resign his office by notifying the Minister in writing and such resignation shall take effect upon the date of the receipt of such document by the Minister.

(5) Where the Chairman or the Deputy Chairman ceases to be a member of the Board, he shall also cease to be Chairman or Deputy Chairman, as the case may be.

(6) The appointment, termination, death or resignation of the Chairman, Deputy Chairman or an appointed member shall be published by notice in the Gazette and by such other means as the Authority deems fit.

4. Vacancies.

(1) A vacancy shall arise in the membership of the Board in the case of —

(a) the death or resignation of a member; or

(b) the termination of any member of the Board in accordance with paragraph 5.

(2) Where a member of the Board is, for a reasonable cause, unable to act as a member, the Chairman shall determine whether the inability would result in a vacancy.

(3) Where a vacancy arises in the membership of the Board, the Chairman shall notify the Minister of the vacancy and the Minister shall, if he thinks it desirable or expedient to so do, revoke the appointment by instrument in writing and appoint another person within fourteen (14) days to fill the vacancy.

5. Termination of membership.

The Minister shall terminate the appointment of a member of the Board where —

(a) there has been proved against the member, or he has been convicted on, a charge in respect of —

(i) an offence involving fraud or dishonesty;

(ii) an offence under any law relating to corruption;

(iii) any other offence punishable with imprisonment, in itself only or in addition to or in lieu of a fine, for more than two years;

(b) the conduct of the member, whether in connection with his duties as member of the Board or otherwise, has been such as to bring discredit to the Board;

(c) the member breaches the clause of confidentiality pursuant to paragraph 10;

(d) the member is adjudged bankrupt;

(e) the member is of unsound mind or is otherwise incapable of discharging his duties;

(f) the member has an interest in a matter before the Board and has failed to disclose that interest, or was present or participated in the deliberations of the matter to which it is necessary for such interest to be disclosed;

(g) in the case of a member of the Board other than the Chairman, such member absence himself from three consecutive meetings of the Board;

(h) the resignation of a member is accepted by the Minister.

6. Remuneration.

There shall be paid —

(a) to each member, in respect of his office such remuneration and allowances, if any, as the Minister may determine;

(b) to the Chairman and to the Deputy Chairman in respect of their offices such remuneration and allowances, if any, in addition to any remuneration or allowances to which they may be entitled in respect of their offices as members; and

(c) to any person invited to attend meetings of the Board under paragraph 7(7) such remuneration and allowances, if any, as the Board may by resolution declare.

7. Meetings of the Board.

(1) The Board shall meet at least eight times per year in such manner and at such times as may be necessary or expedient to do so for the transaction of business and where a member is unable to attend in person, that member may attend the meeting remotely through electronic means approved by the Board.

(2) Not more than sixty days shall lapse between meetings.

(3) The Managing Director shall be entitled to take part in any meeting but shall not be entitled to vote.

(4) The Chairman shall at the request in writing of not less than one-third of the membership of the Board convene an extraordinary meeting of the Board at the time and place determined by the Chairman.

(5) The Chairman shall preside at meetings of the Board, and in the absence of the Chairman or Deputy Chairman, a member of the Board elected by the members present from among their number shall preside.

(6) The quorum of the Board shall consist of a two thirds majority of members.

(7) Matters before the Board shall be decided by a majority of the members present and voting and in the event of an equality of votes, the person presiding shall have a casting vote.

(8) The Board may invite any person, who in the opinion of the Board have expert knowledge concerning any of the functions of the Board that is likely to be of assistance, to attend any meeting of the Board and to take part in its proceedings, but that person shall not be entitled vote on a matter for decision at the meeting.

(9) The proceedings of the Board shall not be invalidated because of a vacancy among the members or a defect in the appointment or qualification of a member.

(10) Subject to this paragraph, the Board shall determine the procedure for its meetings.

8. Voting.

(1) A quorum shall consist of 50%+1 member of the voting members of the Board.

(2) Every voting member shall cast one vote of equal weight or abstain.

(3) The Chairman of the Board shall vote at the same time as the Board on all votes, but the vote shall be kept separate and shall only be considered in the case of a tie to break a deadlock.

9. Disclosure of interest.

(1) A member of the Board who has an interest in a matter for considerations shall —

(a) immediately disclose to the Board, in writing, the nature of the interest and the disclosure shall form part of the record of the consideration of the matter; and

(b) not be present or participate in the deliberations of the Board in respect of that matter.

(2) Unless the Board is fully satisfied that the relationship concerned is not prejudicial to the preservation of the principles of natural justice or public procurement requirements and specifically that the legal requirement that Board proceedings should not be open to the charge of bias, then that member shall take no part in the Board's deliberations on the matter and the disclosure and absence of the member shall be recorded in the minutes.

(3) If any member of the Board is personally the subject of a matter which is before the Board for consideration, that Board member shall withdraw from any deliberations of the Board on the matter and the absence of the member from the deliberations shall be recorded in the minutes.

(4) Notwithstanding subparagraph (3), where the Board is fully satisfied that the presence of the member during such deliberations is not prejudicial to the preservation of the principles of natural justice and, specifically, the legal requirement that Board proceedings should not be open to the charge of bias.

(5) If the Minister is satisfied, after due investigation and following receipt of a recommendation from the Board, that any member of the Board failed, at a material time, to disclose a relationship, he shall remove that person from membership of the Board in accordance with paragraph 3 and any

person so removed shall not be eligible for appointment as a member of any committee.

10. Confidentiality.

(1) A member of the Board shall keep confidential the matters discussed at meetings unless otherwise agreed by the Board.

(2) Where allegations of a breach of confidentiality by a member of the Board arises, the matter shall be brought to the attention of the Minister at the earliest opportunity and the Minister shall cause to be carried out an investigation into the matter.

(3) If the Minister is satisfied, after proper investigation that any member of the Board is in breach of this clause the member shall be removed.

11. Limitation of liability.

(1) Subject to subparagraph (2), no action, prosecution or other proceedings shall be brought or instituted personally against the Chairman or any other member of the Board in respect of any Act done bona fide in pursuance or execution or intended execution of the provisions of the Act.

(2) Where any member of the Board is exempt from liability by reason of subparagraph (1), the Authority shall be liable to the extent that it would be if that member were a servant or agent of the Authority, however, if in any case, the Authority is not liable for any of the above mentioned acts, then subparagraph (1) does not operate to exempt such member as therein stated.

SECOND SCHEDULE

(section 8(1) & (2))

BODIES RESPONSIBLE FOR REGULATING HEALTH CARE PROVIDERS

Nursing Council	Established under section 3 of the Nurses and Midwives Act (*Ch. 225*)
The Bahamas Pharmacy Council	Established under section 3 of the Pharmacy Act *(Ch. 227*)
The Bahamas Medical Council	Referred to under section 4 of the Medical Act, 2014)
Bahamas Dental Council	Established by section 3 of the Dental Act *(Ch. 226)*
Health Professionals Council	Established under section 3 of the Health

	Professions Act *(Ch. 233)*
Hospitals and Health Care Facilities Licensing Board	Established under section 4 of the Hospitals and Health Care Facilities Act *(Ch. 235*

THIRD SCHEDULE

(section 2, 11 &53)

STANDARD HEALTH BENEFIT

The following scope of services are provided under the standard health benefit —

(i) Primary Health Care Services
(ii) Health Education and Promotion
(iii) Early Detection and Preventative Care
(iv) Diagnostic Imaging
(v) Paediatric and Maternity Care
(vi) Screening Programs for Cancer and Other Specified Conditions

FOURTH SCHEDULE

(section 59)

LAW	AMENDMENT
Insurance Act (*Ch. 347*)	Insert immediately after section 206 the following new section — **"206A. National Health Insurance.** Every insurer registered to carry on medical health insurance plans, shall be deemed an approved insurer for the purposes of the National Health Insurance Act, 2022 and shall in respect of all persons insured — (a) provide at a minimum, the scope of services under the standard health benefit specified in the Third Schedule to the National Health Insurance Act, 2022, subject to the terms outlined between the Authority and the approved insurer, except where the insurer has written confirmation from another insurer, that an insured person currently holds a contract of insurance covering the standard health benefit;

(b) require that each insured person —
  (i) selects a primary care provider within the Standard Health Benefit Network under the National Health Insurance Act, 2022; or
  (ii) elects not to select a Provider, with full knowledge of the impacts, financial or otherwise, of opting out;
(c) process claims and provide prior authorization for referrals where necessary and appropriate.".

OBJECTS AND REASONS

This Bill seeks to repeal and replace the National Health Insurance Act, 2016 (the "Act") to provide for a minimum standard health benefit generally by —

(a) providing a safety net for those currently receiving private health insurance coverage where their coverage cannot continue;

(b) reducing the financial burden of eligible and actively enrolled persons in respect to access of health care services;

(c) financing standard health benefit services delivered through public sector institution

Clause 1 of the Bill sets out the Short Title and Commencement. Clause 2 of the Bill contains the interpretation section which sets out the definitions of certain words in the repealed Act.

Clause 3 sets out the objectives and intent of the Bill.

Clause 4 sets out the provisions relative to the continuation of the National Health Insurance Authority (the "Authority")as a body corporate established under the Act. Clause 4 also sets out the provisions relative to the constitution of the Board which acts as the governing and management body of the Authority.

Clause 5 sets out the provisions relative to the use and authentication of the seal of the Authority.

Clause 6 to 8 sets out the powers and functions of the Authority.

Clause 9 and 10 sets out the provisions relative to the daily management of the Authority and appointment of a Managing Director and Compliance Officer.

Clause 11 sets out the powers of the Minister under a declaration of public health emergency.

Clause 12 of the Bill sets out the application of certain provisions in the Public Finance Management Act, 2021 and Public Debt Management Act, 2021 relative to financial matters of the Authority.

Clause 13 sets out the constitution of the funds and resources of the Authority.

Clause 14 sets out the books and records of account to be kept by the Authority and respective audit and inspection measures.

Clause 15 and 16 sets out the power of the Authority to borrow sums of money required to meet its operational objectives and discharge its functions and application of the Public Debt Management Act, 2021 to the Authority's borrowing powers.

Clause 17 sets out the provisions relative to the management and use of the reserve fund to meet certain obligations of the Authority.

Clause 18 sets out the power of the Authority to invest in securities and other financial instruments.

Clauses 19 and 20 sets out the continuation of the National Health Insurance Fund established under the repealed Act.

Clause 21 sets out the continuation of the National Health Insurance Plan established under the repealed Act.

Clauses 22 to 27 set out the provisions relative to the application and enrolment procedure of the National Health Insurance Plan.

Clause 28 sets out the eligibility and entitlement of enrolled persons to the benefits contained in National Health Insurance Plan.

Clause 29 sets out the requirement for every beneficiary to select a primary care provider from the list of Standard Health Benefit Network Providers.

Clause 30 sets out the obligations of beneficiaries to notify the Authority on changes which would impact eligibility to receive benefits under the National Health Insurance Plan.

Clause 31 sets out instances where the National Health Insurance Authority may terminate or suspend benefits of persons under the National Health Insurance Plan.

Clause 32 and 33 sets out the criteria for an insurer under the Insurance Act to be deemed an approved insurer.

Clause 34 and 35 sets out the duties of approved insurers and power of the Authority to issue administrative sanctions, fines, suspend or cancel registration of an approved insurer.

Clause 36 sets out the liability of approved insurers upon cancellation of registration or suspension under the Insurance Act or withdrawal from the business of providing health insurance.

Clause 37 to 39 sets out provisions on eligibility and the requirements for persons not deemed approved insurers to be approved as Standard Health Benefit Providers.

Clause 40 to 42 sets out the functions, and standards regarding quality of care of persons not deemed approved insurers.

Clause 42 to 45 set out the duties of persons not deemed approved insurers under the Bill, and the Authority's powers of inspection and termination.

Part V of the Bill sets out the miscellaneous provisions of the Bill. Clause 48 notes the right of appeal of an aggrieved person. Clause 49 sets out the cooperation and information sharing provisions between the National Health Insurance Authority, the National Health Insurance Board, and the Insurance Commission and clause 50 sets out the confidentiality provisions by persons carrying out functions under the Bill.

Clause 51 and 52 sets out the provisions regarding offences and general penalties for contravention of the provisions of the Bill.

Clause 54 sets out the requirement for an Annual Report to be prepared by the Authority and laid before Parliament.

Clause 56 sets out the power of the Minister to make regulations for carrying out the provisions and objective of the Bill.

Clause 57 sets out the savings provisions of the Bill.

Clause 58 sets out the transitional provisions regarding persons registered as health care providers under the repealed National Health Insurance Act, 2016

Clause 59 sets out the repeal and replacement of the National Health Insurance Act, 2016.