BHF Bowman Letter

Setting the record straight

Issued by Office of the CEO

Executive Summary

As recent as the 11th of December 2023 and 13th February 2024, the Registrar of the CMS had proactively initiated one on one meetings with key board members of the Board of Healthcare Funders (BHF), which included the Managing Director and the Chairperson of the Board to address matters affecting the industry. Most importantly, the meeting was cordial and none of these so-called priority issues that are raised in the Bowman's leaked media letter (dated 16 February 2024) were mentioned by the BHF leadership.

The Bowman's leaked letter to the media certified a long-held view of an unstable leadership at the helm of the Board of Healthcare Funders (BHF). Genuine and pertinent industry concerns raised by its members (medical schemes, administrators) are continuously weaponised through paid media to attack the integrity of the Council for Medical Schemes including its personnel.

The CMS wishes to express its right of reply to the various falsehood perpetuated in the leaked letter by BHF. Ours is to present an unambiguous regulatory response based on empirical evidence. This is solely in the best interest of the medical schemes industry, medical schemes beneficiaries and the public.

For the record, the CMS regulates 71 medical schemes, 32 administrators, 43 managed care organisations, 7 567 accredited health brokers and 2 185 accredited healthcare brokerages. The BHF on the other hand, represents the interests of 40 medical schemes and 5 administrators, and **not** medical schemes beneficiaries.

Media has without any basis also fuelled the false assumption that the BHF was the sole authoritative voice on anything related to the governance of medical schemes. Whilst the BHF's reason for its sole existence was to represent medical schemes and administrators, that of the CMS is to represent the interest of the **9.04 million medical schemes beneficiaries** as found in Section 7 of the Medical Schemes Act. It therefore follows that our mandates and vested interests will not always coincide.

CMS has been characterised by exceptional organisational performance as indicated by the Auditor-General of South Africa, with a clean bill of health of an unqualified audit since inception, and an overall performance score of 89.9%. There were no findings

of fruitless and wasteful expenditure in relation to legal expenditure throughout the years. Suggestions that the CMS is not prudent in how its finances are managed are rejected with the contempt that they deserve, especially in the absence of concrete evidence.

Furthermore, the CMS is a creature of statute reporting to the Ministry of Health, with its Annual Performance Plans and Budgets approved by a legislative process. BHF's own illogical argument is to separate the CMS from the National Department of Health when this relationship is established by legislation.

BHF's favourite topic on curatorship needs to be cleared for all intents and purposes. In order for a Curator to be appointed, an application must be brought before the High Court declaring that the individual or entity is incapable of managing their own affairs. In the last 11 years between 2012 and 2023, only 11 medical schemes had been placed under curatorship by the courts with an average of 1 medical scheme per year. The majority (8) of medical schemes that have been placed under curatorship by the courts were because of governance irregularities. Only (3) medical schemes in the same period were placed under curatorship due to financial issues. Curatorships have largely been reserved for interventions that are aimed at addressing transgressions seeking to threaten the sustainability of a medical scheme. To our records, most schemes that have been placed under the stewardship of a curator have turned around and improved the schemes governance and financial stability and ensured the protection the beneficiary interests.

Another baseless allegation relates to the establishment of the Section 59 Investigation Panel. Early in 2019, several healthcare providers including members of Solutionist Thinkers and the National Health Care Professionals Association made allegations that they were being treated unfairly by medical aid schemes based on race and ethnicity.

The Council for Medical Schemes (CMS) with the concurrence of the Ministry of Health launched an investigation into these allegations (Racism, blacklisting, claw backs, targeting of black professionals) in terms of its regulatory mandate. This led to the establishment of an independent investigation panel to conduct an inquiry into the allegations. The inquiry became known as the Section 59 Inquiry and a final report is thus expected to be delivered in May 2024.

Whilst we readily admit that there have been delays in the release of the final report of the Section 59 investigation, these have been outside the control of the CMS and evidence will support this assertion. The CMS vehemently rejects the notion that the Section 59 investigation was waste of public funds, and we are extremely disturbed that the BHF is using the media to trivialise allegations of bullying, coercion and blacklisting of black health professionals.

Since engagement with BHF is conducted through media, the Office of the Registrar requests evidence where it compelled or forced small schemes to merger with another schemes (our records to date display no such evidence). We also wish to place on record that there have not been any appeals that have been lodged with the different Appeal structures at the CMS to address any matters related to the misconduct of the Office of the Registrar.

The recourse for stakeholders that believe the Office of the Registrar and staff were acting *ultra vires* is found in the Medical Schemes Act and Regulations - and not through public media accusations. This is also captured in Sections 5 & 6 of the Promotion of Administrative Justice Act of 2000.

INTRODUCTION

The correspondence dated the 16th of February 2024, addressed to Honourable Minister Dr. Phaahla and Dr. T Mabeba, in their respective capacities as the Minister of Health and the Chairperson of Council for Medical Schemes (CMS) has reference.

This letter is attached as **Annexure A** for ease of reference. It is the same correspondence that was also deliberately leaked to the media and was reported in various media publications (most notably the **Sunday Times, Medical Brief and Business Live**) in the weekend of the 8th of March 2024. Copies of these publications based on the correspondence are attached as **Annexure B** for ease of reference.

In addressing the different media enquiries during the publication of the contents of the leaked document, the CMS management or the Office of the Registrar was clear that this matter would be comprehensively responded to as soon as the main recipients of the correspondence have had time to consider its contents and formulate their approach to it. Now that these esteemed principals have considered this matter, it is our wish to set the record straight, with respect to the issues raised in the media reports related to the letter delivered by Bowman's Inc. on behalf of the Board of Health Funders (BHF).

It is noteworthy that the BHF is a representative body of 40 Medical Schemes, 5 Administrators and other entities that are regulated by the **CMS as mandated by the Medical Schemes Act 131 of 1998 to protect the interests of members of medical schemes**.

In terms of BHF' s own MOI as attached as **Annexure C**, its primary mandate is to represent its members (medical schemes and administrators' interest) by:

- Lobbying and advocating policy position on behalf of our members.
- Assist members with regulatory compliance.
- Provide legal advice to membership on industry issues.
- Assist in containing healthcare costs.
- Protect the image of the industry.
- Identify and monitor trends.
- impacting our members.

Accordingly, our understanding is that BHF' s primary objectives are to represent the interests of its members (medical schemes and administrators). In contrast, the CMS is legislatively mandated to ***"represent the interests of medical scheme beneficiaries at all times"*** through Section 7 of the MSA, 131 of 1998.

Whilst the BHF reason for existence is to represent medical scheme and administrators, that of the CMS is to represent the interest of the 9.04 million medical schemes beneficiaries. It therefore follows that our mandates and vested interests will not coincide in most instances.

According to section 7 of the Medical Schemes Act (MS Act), the functions of Council are as follows:

(a) protect the **interests of the members at all times**.
(b) control and co-ordinate the functioning of medical schemes in a manner that is **complementary with the national health policy**.
(c) make recommendations to the **Minister on criteria for the measurement of quality and outcomes of the relevant health services** provided for by medical schemes, and such other services as the Council may from time to time determine.
(d) investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act.
(e) collect and disseminate information about private health care.
(f) make rules, not inconsistent with the provisions of this Act for the purpose of the performance of its functions and the exercise of its powers.
(g) advise the Minister on any matter concerning medical schemes; and perform any other functions conferred on the Council by the Minister or by this Act.

The CMS is therefore not surprised that the BHF would place their narrow commercial and vested interests of its members (medical schemes, administrators and others) above those of the 9.04 million medical scheme beneficiaries of medical schemes.

It is also important to note that the BHF may be representing a combined total 40 medical schemes and administrators, they are not the sole representatives of all the schemes in the Republic of South Africa as there are **71 medical schemes and 32 Administrators currently registered with the Council of Medical Schemes.**

They should therefore not be considered as the collective representative voice of all medical schemes in the country but are one of the key stakeholders.

Throughout the lengthy 8-page correspondence referred to above as **Annexure A**, there is no attempt to directly raise any issue that may be of interest to the beneficiaries of medical schemes whose interest we regulate to protect.

It is therefore our understanding that the correspondence is aimed at securing and protecting the interests of medical schemes including administrators and not those of the **9.04 million** medical scheme beneficiaries.

In this document, we will respond to the issues raised in the media enquiries in relation to the correspondence to the Minister of Health and the Chairperson of Council as well as some of the issues that were raised in the published media reports that followed. Our response is going to be largely confined to the specific allegations that have been levelled against the Office of the Registrar and will not respond to all the requests for information that are specifically directed to the Chairperson of Council.

The Council for Medical Schemes hereby states that any omission to address any matter raised in these articles about the CMS should not be considered as an admission of guilt.

ADDRESSING THE ALLEGATIONS

In the publication following the release of the correspondence to the Minister and Chairperson, there were serious allegations that were levelled at the Office of the Registrar to the effect that:

- *The conduct of the Registrar and his staff is not in accordance with the Medical Schemes Act, and that.*
- *There were concerns regarding the supervision of the industry by the Registrar and the staff of the CMS; and*
- *There were also concerns related to the competence and conduct of the Registrar.*

The Registrar and the CMS staff collectively also referred to as the Office of the Registrar conduct their regulatory work under the auspices of the Medical Schemes Act 131 of 1998 and the associated regulations.

The MS Act itself provides for specific restraints, remedies and protection of all stakeholders from unwarranted and conduct that is *ultra vires* by the Office of the Registrar, and the entire industry including the BHF are aware of these. The remedies are found in chapter 10 of the Medical Schemes Act 131 of 1998 and are hereby stated below.

- **Complaints and Adjudication Process**

  *"**47**(1) The Registrar shall, where a written complaint in relation to any matter provided for in this Act has been lodged with the Council, finish the party complained against with full particulars of the complaint and request such party to furnish the Registrar with his or her written comments thereon within 30 days or such further period as the Registrar may allow.*

  (2) The Registrar shall, as soon as possible stir receipt of any comments furnished to him or her as contemplated in subsection (1), either resolve the matter or submit the complaint together with such comments, if any, to the Council, and the Council shall thereupon take all such steps as it may deem necessary to resolve the complaint."

- **Appeal to Council**

  *"**48**(1) Any person who may be aggrieved by any decision relating to the settlement of a complaint or dispute appeal against such decision to the Council.*

- **Appeal against decision of Registrar.**

  *"**49**(1) Any person who is aggrieved by any decision of the Registrar under a power conferred or a duty imposed upon him or her by or under this Act, excluding a decision that has been made with the concurrence of the Council, may within 30 days after the date on which such decision was given, appeal against such decision to the Council and the Council may make such order on the appeal as it may deem just.*

- **Appeal Board**

  *"**50** (3) Any person aggrieved by a decision of the Registrar acting with the concurrence of the Council or by a decision of the Council under a power conferred or a duty imposed upon it by or under this Act, may within a period of 60 days after the date on which such decision was given and upon payment to the Registrar of the prescribed fee, appeal against such decision to the Appeal Board."*

The Appeal Committee, the Independent Appeals Board as well as the High Court and other courts are on a frequent basis seized with the tasks of reviewing the rulings and any actions undertaken by the Office of the Registrar to ensure that these are fair, just and lawful. In other words, the Office of the Registrar is prohibited to be a "*law unto itself*" and there are checks and balances to ensure that any act that is outside the law is curbed and restrained.

The recourse for stakeholders that believe that the Registrar and staff are acting *ultra vires* is found in the Medical Schemes Act and regulations and not through public media accusations. This is also captured in Sections 5 & 6 of the Promotion of Administrative Justice Act of 2000.

> "***5**(1) Any person whose rights have been materially and adversely affected by administrative action and who has not been given reasons for the action may,*

within 90 days after the date on which that person became aware of the action or might reasonably have been expected to have become aware of the action, request that the administrator concerned furnish written reasons for the action…."

And

*"**6**(1) Any person may institute proceedings in a court or a tribunal for the judicial review of an administrative action."*

The core regulatory activities that the Office of the Registrar is engaged in, is largely adjudicative. While conducting this adjudicative regulatory work in the medical schemes industry based on the Medical Scheme's Act, the Office of the Registrar will in the majority of cases get things right. There will however be exceptions where its rulings are challenged by the stakeholders as provided for in the Act. We are therefore surprised that the BHF seems to have adopted the view that where their members differ with the regulatory decisions or conduct by the CMS, this is seen not to be in accordance with the Act.

Our expectations are that the BHF and its constituent membership, would have followed this route that is prescribed and clearly articulated in Sections **47, 48, 49 and 50** of the Act as referred to above to address any real or perceived overreach by the Office of the Registrar in its regulatory activities.

We also wish to place on record that there are no appeals that have been lodged with the different Appeal structures at the CMS to address any matters related to the misconduct of the Office of the Registrar.

We therefore find the recent combative conduct by the BHF leadership of addressing these concerns with the Minister of Health, the Chairperson of Council and through the media as extreme, bizarre and not in accordance with common sense as well as the prescripts of the Medical Schemes Act and regulations.

We are also deeply concerned that aspersions are being cast at the conduct and competence of the Office of the Registrar without any shred of evidence being provided. We note these baseless assertions for what they are and their intentions, which is to besmirch the professional reputations of all those dedicated and highly competent individuals that are serving in the Office of the Registrar.

In our published Annual Report, which is a public document, the competence, and achievements of the Office of the Registrar, are there for all to see. A summary of these achievements is listed below to illustrate this point:

CMS has been characterised by exceptional organisational performance as indicated by the Auditor-General of South Africa under the following categories for the financial year of 2022/2023:

- *In the 2022/23 Financial year the CMS received an 89% Organisational performance output and an **unqualified Audit outcome**.*
- *3 017 Complaints resolved.*
- *1 200 clinical complaints and opinions processed.*
- *39 Appeals resolved.*
- *7 Appeals Board matters.*
- *26 600 Customer care calls handled.*
- *47 Consumer education outreach sessions.*
- *2 Board of Trustee training sessions.*
- *3 Broker training sessions.*
- *2 Scheme-specific training sessions.*
- *3 Trustee Development Programme blocks with Gordon Institute of Business Sciences (GIBS).*
- *12 CMS script newsletters and 63 Circulars published.*
- *4 Research studies and 3 Published research papers.*
- *10 Prescribed Minimum Benefit Definition Guidelines*
- *6 Fraud, Waste and Abuse engagements and 12 Fraud, Waste and Abuse signatories.*
- *3 Principal Officer and Board of Trustee forums*
- *14 Memoranda of Understanding (MoU)*
- *52 Annual General Meetings undertaken by schemes observed.*
- *3 Governance Interventions (curatorship and statutory management).*

The achievement of an unqualified audit outcome by the CMS, since its inception, is a record that we are very proud of. Throughout these audits that are conducted by the AGSA and investigated, compliance with the PFMA and other legislation, amongst

others, there has never been a finding of fruitless and wasteful expenditure linked the legal expenditure.

We would also like to place it on record that the behaviour, experience, aptitude, knowledge, and skills of the personnel serving in the Office of the Registrar are exceptional and above average for this industry. We are instead faced with the challenge that constituent members of the BHF and others are continuously recruiting key personnel from the CMS, and we are certain, that this is not based on their incompetence or their penchant for illegal conduct.

We take note of the threat by the BHF to lodge a complaint with the Public Protector should they not be satisfied with the way the Council will address these complaints and allegations. We, however, believe that this veiled threat to the Council and the Minister is pre-emptive, unjustified, and unfair. This approach reveals the true intention of this letter by the BHF, which is to publicly tarnish the reputation of the CMS for reasons best known to them.

A question that however begs to be answered by the BHF is what engagements have they had with the Office of the Registrar to address the issues that they are now raising that has caused them to escalate these matters to both the Chair of Council and the Minister?

In the period between 2017 when the Registrar was formally appointed and the outbreak of the Covid-19 pandemic, the Registrar had on more than three separate occasions, suggested the signing of an MOU between the CMS and BHF.

Furthermore, the CMS furnished copies of draft MoU's that would create a platform for scheduled and regular engagements between itself and the BHF to address **ALL** matters of concern by its own members including those that are cited in the leaked document. All these three attempts failed due to lack of interest on the side of the BHF leadership (**We have evidence to prove this**).

During the Covid-19 pandemic, the medical schemes administrators and their representative bodies such as BHF, HFA and non-affiliated medical schemes worked very closely with the CMS with great success. These achievements included creating access to medical scheme members, the required vaccines against Covid-19, the declaration of Covid-19 as a PMB, the reduction of the costs of the lab tests by 41%

and the development of a draft multilateral tariff negotiation framework. The CMS also collaborated with key industry stakeholders including the BHF in establishing key structures principles and charters to combat Fraud, Waste and Abuse in the industry.

This level of co-operation has been recently undermined by the tendency of the BHF to rush to the media without any meaningful engagements on key issues with the Regulator (CMS) yet opts to play to the gallery. CMS regards this approach as immature, unproductive and uncalled for. This industry requires leadership that is matured, progressive and places the interest of health-care patients and medical scheme beneficiaries at the centre of its decision-making and policy approach.

As recent as the 11th of December 2023 and 13th February 2024, the Registrar of the CMS proactively initiated one on one meetings with key board members of the BHF, which included the Managing Director and the Chairperson of the Board to address matters affecting the industry and what they wanted the CMS to intervene on. In these meetings that were handled in a very cordial manner, none of these so-called priority issues that are raised in the letter were mentioned by the BHF leadership. The fact that these matters are now raised in a public platform in the manner that they have been raised and escalated, has taken all of us at the CMS by surprise.

The conduct of the leadership of the BHF in failing to address these issues of importance raised by their membership is extremely disappointing and demonstrates lack of integrity, courage, accountability, and honesty. During the failed attempts to obtain an MoU signed with the BHF, the issues that are now being aired in public were flagged as being important for discussion. We are of the view that if these matters had been raised in the meetings with the Registrar or the MoU discussions, the CMS would have meaningfully contributed to their resolution and the need to ventilate them in the public platform would not have arisen.

The publishing in the media of key important issues that are of a policy or regulatory nature without the engagement with the regulator results in the misrepresentation of facts and the interests of the beneficiaries.

These published media articles under discussions also draw the wrong conclusion that all these regulatory decisions and/or actions that are taken by the Office of the Registrar are based on individual preferences rather than in terms of the MS Act.

BULLYING OF MEDICAL SCHEMES

We vehemently reject the allegation that the CMS is bullying medical schemes into extinction, liquidations and through forced mergers. Whilst the CMS believes in the sound policy approach of consolidation that supports large and self-sustaining risk pools based on evidence but the CMS **has never** compelled nor advised any scheme to merge with another. There is no record where a scheme has complained to the Appeal structures of the CMS that they have been compelled to merge with another scheme by the Office of Registrar.

We have already indicated in the discussion above that the course of action for medical scheme to take where the Registrar may be acting outside the MS Act, to date no medical scheme has come forward to make these spurious allegations. The CMS and its appeal structures would welcome a substantiated case in this respect. In the Principal Officer (PO Forum) and Board of Trustee Forum which are regularly convened by the Office of the Registrar to address industry wide challenges, no such allegations had been raised and/or levelled by members of BHF. The root-cause and source of these bullying allegations are surprising to the CMS.

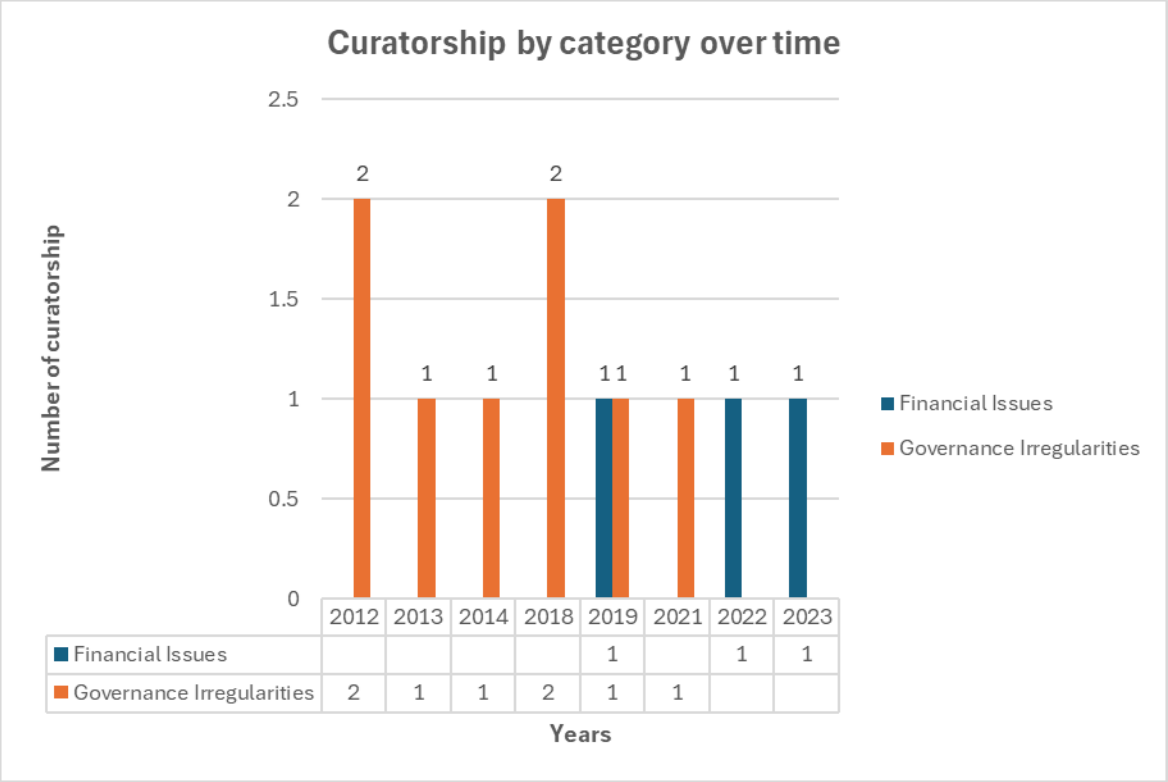
CURATORSHIPS

There are several regulatory tools available to the CMS to address transgressions and non-compliance with the provisions of the MSA with its associated legislations and regulations. Included amongst these tools is the placement of medical scheme under curatorship. The CMS as a regulator is an implementor of legislation and not a law-making body. Therefore, arguments aimed at attacking the constitutionality of specific provisions contained in the MS Act and others cannot be resolved by CMS but by legislators. The processing of the Medical Schemes Amendment Bill (MSAB) will provide the BHF and other key stakeholders with an opportunity to air their legislative concerns.

A curatorship is a process whereby a Court appoints a Curator to manage and protect the finances, property, or estate of another who cannot do so for themselves; or in this case a Curator appointed by a court to act as a legal representative for the medical scheme.

For a Curator to be appointed, an application must be brought before the High Court declaring the individual or entity incapable of managing their own affairs.

The CMS has been very circumspect in the manner that it has utilisde this tool because of its invasive nature. Curatorship has largely been reserved for interventions that are aimed at addressing transgression that are threatening the sustainability of a medical scheme. The sustainability issues where curatorship have been implemented often includes a rapidly deteriorating financial health and major governance issues in a medical scheme.



In the graph illustrated above, it can be concluded that in the last 11 years between 2012 and 2023, only 11 medical schemes have been placed under curatorship by the courts with an average of 1 medical scheme per year. The majority (8) of medical schemes that have been placed under curatorship by the court were as a result of governance irregularities. Only (3) medical schemes during this period where placed under curatorship due to financial issues. Between 2012 and 2022, eleven (11) medical schemes were placed under curatorship. In proportion to the total number of medical schemes during the same period, this represented approximately **14%** of all medical schemes. In terms of several lives covered, the affected schemes accounted for **6%** of the medical scheme industry. These statistics highlight the insignificant impact on affected schemes, countering the perception that regulators act hastily in placing schemes under curatorship**.**

The accusation that CMS frequently and recklessly uses Curatorship as a blunt instrument that is implemented without due consideration of less intrusive interventions in a manner that is aimed at intimidating medical schemes is not supported by the analysis and facts as presented above.

The regulatory interventions that the CMS employs at medical schemes and other regulated entities are driven by our mandate in section 7 of the MS Act, namely, to

always protect the interest of beneficiaries. These regulatory interventions are not implemented in line with the whims and wishes of individuals at CMS and there is a clear procedure that is followed before a medical scheme is placed under curatorship.

In instituting a curatorship, the Registrar is guided and empowered by Section 56(1) which reads:

> *"the Registrar may, notwithstanding the provisions of sections 52 and 53, if he or she is of the opinion that it is in the interest of members or that it is desirable to do so, because material irregularities have come to his or her notice, or because a medical scheme is not in a sound financial condition or as a result of an inspection of the affairs of a medical scheme, apply, with the concurrence of the Council, to the High Court, for the appointment of a curator to tie control of and to manage the business of that medical scheme.*

Even when the office of the Registrar is convinced that the invasive intervention such as the placement of a medical scheme under curatorship is the best remedy to protect the interest of the medical scheme's beneficiaries, it is still expected to make a case to the governing body (Council) in order to obtain concurrence. If you examine the history of medical schemes that have been placed under curatorship between 2017 to date, all these interventions were taken with the concurrence of Council. This concurrence has also in all instances been supported by an external legal opinion.

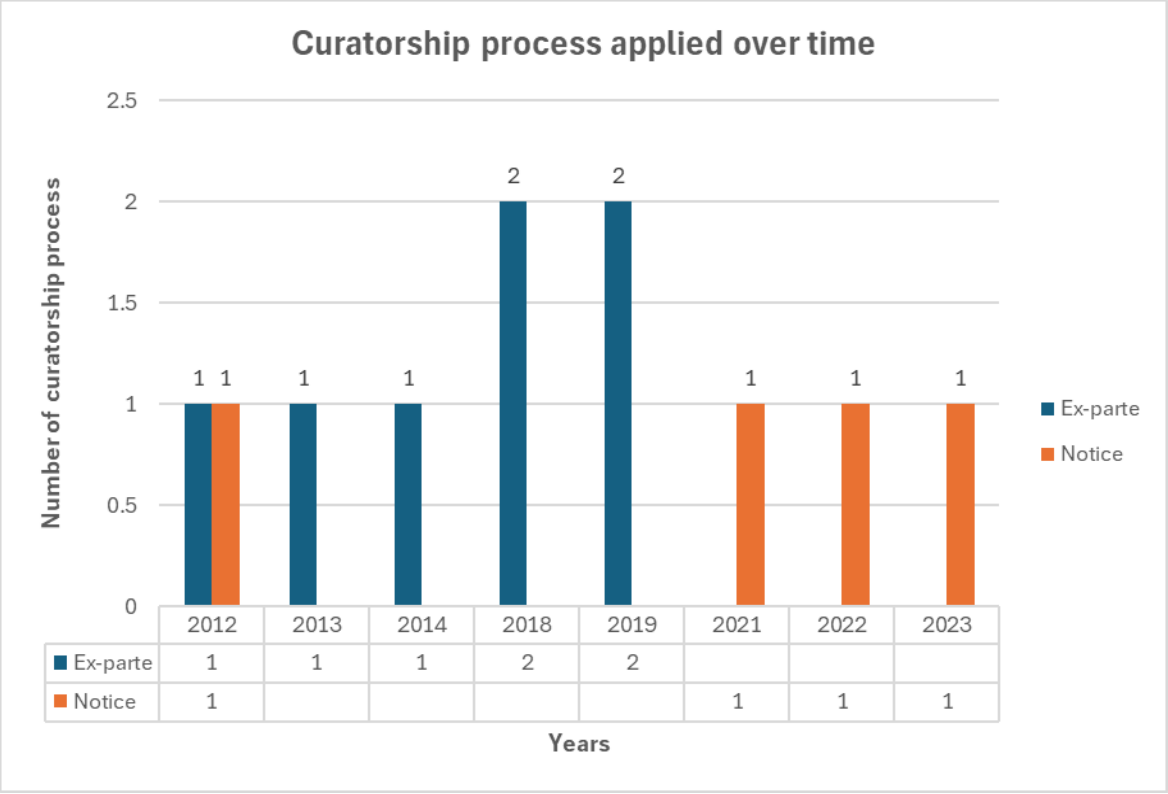
The placement of a medical scheme under curatorship does not fall within the jurisdiction of the powers of the Office of the Registrar and Council, instead these powers fall within the judicial discretion of the court of the land. The BHF appears to bestow the powers of placing medical schemes under curatorship to either the Office of the Registrar or the Council and this is a clear of misunderstanding of the application of the relevant legislation.

The curator that is placed by the court at a medical scheme are not appointed by the CMS but by the courts and these individuals are officers of the court and acting under the supervision of the judicial system. Even the removal of a curator placed at a medical scheme is a function that can only be conducted by a court of law. The judicial system or courts will only place a medical scheme under curatorship if and only when it believes that the Registrar in concurrence with Council have made out a credibly and justifiable case in protection of beneficiary interests. The medical schemes are

also given an opportunity to challenge and make out a case of why a curatorship should not be granted; most medical schemes have used this defence and opportunity.

When circumstances at a medical scheme level are dire and require a more urgent intervention such as the placement of a curator to protect member interest, the law allows for this to be done through what is referred to as an *ex-parte process*. Even in these instances where urgent interventions are warranted, the Office of the Registrar in concurrence with Council still require a court order. The reason for *ex-parte* is where extremely urgent interventions are necessary to save the medical scheme or to place an independent party to prevent nefarious activities from taking place e.g. misappropriation or destruction of evidence. The basis for *ex-parte* is not to forewarn those that may be implicated in such acts.

The *ex-parte* application is not an invention of the CMS, it is law. Below is an illustration of key circumstances wherein *ex-parte* applications where utilised by the CMS.



In the period between 2012 and 2023, the CMS was able to present sound cases to the courts to place 7 medical schemes under curatorship through an ex-parte procedure. This means that the courts in these 7 instances agreed with the regulator that the implementation of the *ex-parte* is the most appropriate and justified under

those circumstances. There is only *one ex-parte* application that was launched by the CMS and was refused by the court, in the period under consideration.

During the same period, 4 medical schemes were placed under curatorship through a notice process. This negates the view that whenever CMS launches a court application on curatorship, it is ordinarily on an *ex-parte* basis. The *ex-parte* application generally follows the below process:

The court requires a legal assessment for the basis of the curatorship (section 56 of the MS Act and section 5(1) FI Act) and the need for a curator. These are commonly contained in a report that results from routine inspections or investigations instituted from tip-offs or complaints brought forth.

- **Court Hearing and Appointment:** The court will hold a hearing to consider the evidence and determine whether the appointment of a curator is necessary and in the best interests of the medical scheme and its beneficiates.

  If granted, the court will appoint a suitable person as curator.

The allegation that CMS is using *ex-part* to bully medical schemes into curatorship is misplaced and shows a lack of understanding the legislative framework. The outcome of legal proceedings is dependent on various factors, but we are comfortable that in all *ex-parte* applications, there have been justifications that sufficient reasons to bring such *ex-parte* curatorship applications and the court have been in agreement with the CMS. The allegation that medical schemes are being bullied through *ex-parte* applications can only be sustained if the courts have persistently and consistently ruled.

CMS has no intentions to abandon *ex-parte* curatorship applications where these are warranted and justified and are the only recourse to protect members interest. The *ex-parte* application for placement of medical schemes under curatorship remains one of the effective regulatory tools at the disposal of the CMS who remain the designated regulator in the medical schemes industry. These allegations of bullying of medical schemes actually serve as a testimony to the effective regulatory interventions of the CMS based on the analysis as indicated above.

In the section above, CMS has demonstrated that before a medical scheme is placed under curatorship whether through an *ex-part* or not, several barriers would need to

be traversed i.e., support by an external legal opinion, concurrence by Council and a court judgement. It can therefore never be said that the CMS invokes these curatorships dispensations at will, as we are not in total control of these processes.

The appointment of curators is done in accordance with the provisions of section 56 of the Act read with the provisions of the Financial Institutions (Investment of Funds) Act, 1984. If the Registrar is of the opinion that it is in the interest of members or that it is desirable to do so, because material irregularities have come to his or her notice, or because a medical scheme is not in a sound financial condition or as a result of an inspection of the affairs of a medical scheme, apply, with the concurrence of the Council, to the High Court, for the appointment of a curator to tie control of and to manage the business of that medical scheme.

It is also important to note that the decision to appoint a curator is that of the court and not CMS. CMS only recommends and it is up to the judge hearing the application to make the final decision.

You are drawn to Section 56 of the MSA as read with Section 5 (1) of the Protection of Funds Act for procedures and requirements in relation to institutions of curatorships into medical schemes. Case law (Polmed versus Council for Medical Schemes Case No 2461/2020 by Kubushi J, Gauteng Division, Pretoria) can attest to this position of curatorship *(ex parte)* as contained in the attached judgement, more particularly in relation to paragraph 41 which reads in verbatim.

> *"The Registrar is empowered by section 5 (1) of the Protection of Funds Act to bring an ex parte application before the Court. The section further grants the Registrar the discretion to decide whether to bring an application on ex parte basis or not. Once the Registrar exercises the discretion to bring the application on ex parte basis, the application must be brought on good cause shown. It means that the Registrar must convince the Court that there is justification to grant the application ex parte without notice to the other party."*

In addition, we would like to inform you that curatorship interventions have been successful in restoring governance and sustainability at the medical schemes, thus ensuring continued coverage of beneficiaries. Notable successful curatorship intervention by CMS.

Ex parte applications are allowed and governed by the Magistrates and High Court Rules dealing with applications and provides for the following procedure:

(a) No application in which relief is claimed against another party shall be considered ex parte unless the court is satisfied that – (i) the giving of notice to the party against whom the order is claimed would defeat the purpose of the application; or (ii) the degree of urgency is so great that it justifies dispensing with notice.

(b) Any order made against a party on an ex parte basis shall be of an interim nature and shall call upon the party against whom it is made to appear 4 before the court on a specified return date to show cause why the order should not be confirmed.

(c) Any person against whom an order is granted ex parte may anticipate the return day upon delivery of not less than twenty-four hours' notice.

(d) A copy of any order made ex parte and of the affidavit, if any, on which it was made shall be served forthwith on the respondent thereto.

(e) Where cause is shown against any such order the court may order the applicant or respondent or the deponent to any such affidavit to attend for examination or cross-examination.

(f) Any order made ex parte may be discharged or varied by the court on cause shown by any person affected thereby and, on such terms, as to costs as may be just.

(g) Ex parte applications may be heard in chambers.

These good outcomes by placement of a curator, clearly demonstrates that CMS has not abused the law and instead protected beneficiaries of medical schemes.

UNDUE INFLUENCE BY AND CLOSE RELATIONSHIP WITH NDOH

The perpetual narrative circulating in media that the National Department of Health (NDOH) influences the CMS again demonstrates the lack of understanding of governance and institutional arrangement in which the CMS operates. The regulator is a creature of statute in terms of Section 7 of the Medical Schemes Act and is a schedule 3A public entity in terms of the Public Finance Management Act. As such, the CMS has its own governing body also referred to as the Council designated as the Accounting Authority of the CMS. Section 7 of MSA further stipulates that Council must advise the Minister on various national health policy matters and in turn the Minister confer any tasks to the Council as he deems fit. In terms of the PFMA, the Minister of Health is the Executive Authority of the CMS and presents and recommends its budgets and plan to Parliament. The relationship that exists between the CMS and the NDOH is not based on personal whims, but is established by law.

POLICY MATTERS

It appears that the BHF is mainly concerned and seeks to challenge the health-policy direction that the NDOH under the leadership of the Minister of Health is taking. This is exemplified by the comments and or allegations with respect to the LCBO, PMB and the NHI. It should be noted that despite its many utterances to the contrary, the BHF is not in support of the NHI. It should also be noted that their position in respect of the LCBO is to argue for its introduction irrespective of its impact that this may have on the entire health-system and the 62 million of the SA population.

The policy stance of the BHF on the NHI, LCBO and PMB is political and ideologically linked to the stance adopted by the most conservative elements in the health space. The allegations and arguments presented and reported on regarding these key policy issues are not new. These have been ventilated by the same BHF in the many consultative processes that have been initiated by the CMS. The intention of the BHF in raising these policy issues is to place pressure on the Minister of Health to support their cause on the LCBO that is largely driven by commercial interests.

The approach by the BHF of canvassing these key policy issues in the public domain, the Minister, Council for Medical Schemes, Public Protector, and the Health-

Ombudsman are clear indication of an organisation that has run-out of creative ideas and are now resorting to forum shopping to remain relevant and gain support. Whilst we understand that BHF is a lobbying group by definition and intention, CMS believes that its strategies and tactics are poorly conceived and badly implemented. This is exemplified by the fact that they have failed miserably to influence through their combative and negative approaches. Successful lobbying is premised on winning key arguments by providing undisputed, scientific facts and not on empty legal threats and public insults.

Most of the industry matters depicted in the media article are policy-related and with multiple interests, requiring industry-wide consultations. These consultations by their nature often take time to reach a final outcome because all stakeholder concerns ought to be taken on board. Some contributing barriers to the finalization and implementation of these key policy matters stem from legal challenges and appeals brought forward by certain industry players. The CMS ensures adherence to constitutional processes to engage and consult all affected parties.

The Low-Cost Benefit Options Framework

The finalisation of the LCBO framework is currently in progress. The industry consultations that resumed in 2020 were concluded by the end of 2022. Circular 3 of 2022 was subsequently published as the outcome of these consultations and was made available for public comment, marking the final stage of the consultation process.

The LCBO report has since been furnished to the Minister of Health in November 2023. CMS remains as a critical player in the final decision still to be made by the Minister. The custodian of the LCBO report is the Minister of Health and all stakeholders should await the Minister’s final decision on the recommendations. CMS should not and will not share the contents of this LCBO report until CMS has been specifically furnished with instructions and/or permissions to do so by the Minister of Health.

The PMB review

PMB's are the only guaranteed rights, entitlements and benefits that members enjoy under the medical scheme's dispensation. If this dispensation is removed as proposed by some stakeholders in the guise for cost effectiveness and affordability, then medical schemes will decide through a discretionary process of whether to honour claim or not. The PMB's form a fundamental pillar of how the CMS through its regulatory processed protects beneficiaries.

The CMS carries out reviews of the Prescribed Minimum Benefits (PMB) through the PMB Benefit Definitions Project and the CMS scripts. Resulting from these reviews which are regularly published in the public domain. Annually, the CMS publishes 10 PMB definitions and CMS scripts, as outlined in the annual performance plan. The costing of the Primary Healthcare (PHC) package has been completed, and the CMS is currently finalizing the affordability framework. Once concluded, it will be deliberated at relevant committees, including the PMB Priority Setting Committee and the PMB Advisory Committees, following industry consultations. The industry is provided with regular updates, and the most recent update can be found in Circular 15 of 2023.

The Code of Conduct, Scripts, Definitions, Consultative process to determine affordability, BHF formed part of these committees since their inception until to date (BHF has been part of this journey). These reports have sometimes not been welcomed by some of the industry players where these are not aligned to their commercial interests.

The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of Private and Public Health Care resources. The National Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa.

Consequently, the NDOH monitors the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review is expected to be conducted at

least every two years by the Department involves the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives.

In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of—

- inconsistencies or flaws in the current regulations.
- the cost-effectiveness of health technologies or interventions.
- consistency with developments in health policy and
- the impact on medical scheme viability and its affordability to members.

The Solvency (RBC) Framework

The Medical Schemes Act currently does not include provisions for the Risk Solvency Framework, making it neither mandatory nor legislated. However, the CMS has engaged the services of an expert to conduct an impact assessment of its implementation and provide recommendations in this regard. One of the primary considerations is whether to adopt it as a monitoring tool rather than enforcing it at the industry level. Therefore, there is no expectation that it will be implemented at the industry level until the CMS is satisfied that it can be implemented without destabilising the industry.

Purpose of Circular 27 of 2023

The CMS regulatory mandate is to be effective and efficient. This would include the outlining the requirements for annual contribution increases and benefit adjustments submissions. At a media briefing in June 2023, the CMS;

- Communicated the key factors that the CMS will consider when assessing the appropriateness of changes.
- Requirement for medical schemes to submit relevant documents and appendices as requested in the Circular.

- Medical schemes were advised against communicating any benefit changes or contribution increases before obtaining the necessary approval from the regulator.

A medical scheme may, in accordance with Section 31(1), make or change any rule, or rescind any rule, in the manner provided for in its rules. According to Section 31(2), amendments, rescissions, or additions to any rule are considered valid only if the Registrar has approved them. Announcements of changes to benefits and contributions for 2024;

- Five (5) out of 71 schemes made public pronouncements on changes to benefits and contributions for 2024 (without reference to Section 31 (2)).
- The announcements caused unnecessary confusion among medical scheme members and the public.
- The trustees acted without due care and in bad faith and in contravention of Section 57 (6) (b) of the MSA and
- Failure to inform members that the communication relating to rule amendments is subject to the Registrar's approval constituted a contravention of Section 57 (4) (d) of the MSA.

Furthermore, the CMS had engaged with the 5 affected medical schemes. The Office of the Registrar issued Section 43 directives that were intended for the specific medical schemes. One administrator was recently issued with a directive on how to or how not to communicate on behalf of the scheme after a finding that its press releases contravened section 21A.

The office dealt with a high number of complaints relating to the announcement of benefit and contribution changes. Medical schemes immediately withdrew the announcements of the proposed benefit and contribution changes. One medical scheme provided evidence that its announcement was consistent with Circular 27 of 2023. The affected medical scheme was considered to have fully complied. The matter was considered closed.

ALLEGATION OF LACK OF CONCURRENCE BY CMS

The fact that CMS has been operating without concurrence in terms of the Twin Peaks is misplaced, CMS has been operating with the transitional extensions since 2019 to exclude concurrence for the past few year in line with the FSRA and can confidently confirm that no concurrence amongst the three regulator is required due to the suspension effect of the gazette ending March 2024 and the further gazette that has been published which further suspend the need for concurrence by another three years (March 2027).

There are technical teams to develop a concurrence framework to address the determinations and their scope. The discussions are very cordial and co-operative. This is information that CMS could have easily shared with the BHF without the unnecessary noise in the media.

CONCLUSION

We have indicated that where affected parties are of the view that the Registrar is acting outside the process, robust and resilient remedies are available under the MS Act and the power to place on curatorships is fully entrenched under section 56 of the MS Act. CMS enjoy a great track record on curatorships and statutory managers and how these have positively turned around the fortunes of medical schemes.

The allegation that CMS is acting under the guidance of the Minister is misplaced, the reporting lines of the CMS are clear in terms of section 7 of the MS Act and PFMA more specifically Section 3A entity under PFMA. The Budget approvals of the CMS as shown above are in line with the PFMA and approved by the Minister of Health as its executive authority and the 5 years CMS APPs have shows that CMS is operating and performing as expected and in line with its mandate.

The accusations in relation to Curatorship's are baseless and as shown, ex parte applications are common legal remedies. If there is a shift not to apply ex-parte applications, then changes to the law have to be made but unfortunately, CMS is not a policy nor a law maker. No form of bullying could be found within our quantitative analysis and as shown above, as such the bullying allegation is without merit.

CMS disagrees that the Section 59 investigation was waste of public money because in early 2019, a number of healthcare providers and members of Solutionist Thinkers and the National Health Care Professionals Association made allegations that they were being treated unfairly by medical aid schemes based on race and ethnicity.

The Council for Medical Schemes (CMS) launched an investigation into these allegations (Racism, blacklisting, claw backs, targeting of black professionals) in terms of its regulatory mandate. This led to the establishment of an independent investigation panel to conduct an inquiry into these allegations. The inquiry became known as the Section 59 Inquiry. The Panel members are Advocate Tembeka Ngcukaitobi SC (Chairperson); Advocate Adila Hassim; and Advocate Kerry Williams. BHF was part of Section 59 Steering Committee and Section 59 Investigation is a matter of public interest in the post-apartheid South Africa

In practice urgent and life-threating appeals are prioritised to the extent that some are brought to our notice by our counterparts, appellants and /or schemes. A joint process

to develop a seamless and joint SOP with Complaints Adjudication is in motion that will address issues of referral and set downs with regular feedback to the two Units.

Council is in a process to explore the possibility to outsource the adjudicative aspect of appeals to a panel that could operate independently and on weekly basis. The format of appeal resolutions will change to provide for one person hearings in uncomplicated matters that could be resolved on paper and three panel members on complicated medical and regulatory matters. The Appeals Committee would remain as an oversight governance committee that will oversee the work of the independent adjudicative panel.

We agree with BHF, the slowness is however attributable to the schemes themselves. Medical Schemes have shown little respect to the current appeals processes and have consistently abuse them to the detriment of member interests. Schemes challenge every decision, litigious nature and abusing the Appeal Processes resulting in heavy backlogs and taking advantage of suspensory nature of the decisions.

CMS wants to accelerate the legislative reforms (current MSA Bill – wants to create one appeals structure to remove multiple appeals structures). We have publicly indicated our willingness to engage with stakeholders on key issues that should be fast tracked to support improved regulation.

Unfortunately, the Risk based solvency is not part of the MSA or its regulation and it was a research project aimed at looking for an alternative manner of regulating solvency. It is up to the CMS to decide whether to implement the final outcome of this process taking into account its overall impact on the medical schemes' environment. Study undertaken shows that model is likely to advantage larger medical schemes and disenfranchise small medical schemes. We will continuously review this important tool and will only implement it when we are certain that it will no cause industry instability.

The allegation of lack of concurrence with FSCA and PA constitute a curious interpretation of FSRA, there are transitional arrangements **(Annexure D)** and BHF is out of touch with the ongoing discussions between CMS, NDOH, FSCA, PA and National Treasury. We see this as a fishing expedition of information they are not entitled to.

The publications also show a lack of understanding of Council protocols and processes and attempting to bait Council and the Registrar to pronounce on decisions that are yet to be made through prescribed legitimate processes. This amount to unethical questions and questionable conduct

The LCBO Report is under the jurisdiction of the Minister, and we see this repeated request as attempting to undermine the Ministers decision.

CMS by itself cannot be held liable for PMB Review, review process is depended on stakeholders **(Annexure A)** and there many areas of contention among stakeholders. CMS is trying to foster an inclusive and collaborative approach continuous and consultative process.

The progress on the review is continuously slowed down by the vested interests of parties involved and BHF has been involved in the PMB Advisory Committee as a stakeholder and are equally to blame for the slow output- like all other parties. Several outputs to date on PMBs (code of conduct, scripts, Definition and Guidelines, COVID-19 regulations on PMB and vaccines). IT is therefore incorrect to suggest that nothing has been done to date on the PMB review.

This dossier shows that there is no maladministration into the CMS. These articles seem to be confused and the main intention seems to be to destroy relations with CMS and schemes and in the same breath tarnish the image of the regulator in the public eye.

We are again indicating our willingness to engage with any key industry stakeholder including the BHF on any matter affecting the industry. Also, we are inviting the BHF to engage and sign an MOU with us, which will provide them with a platform for strategic engagements on a regular and scheduled basis, without prejudice with the regulator. This will also ensure that they are able to address the interests of their members truly and genuinely instead of resorting to forum shopping via a media circus.

Annexure A: BHF LETTER

https://shorturl.at/kwZ89

Annexure B: COPIES OF MEDIA ARTICLES

https://shorturl.at/erCY0

Annexure C: BHF'S MOI

https://shorturl.at/rX126

Annexure D: FSRA

https://shorturl.at/joyY1