

No.]

Universal Health Coverage Act

SAINT LUCIA

No. of 2026

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SCHEDULE

BE IT ENACTED by the King's Most Excellent Majesty, by and with the advice and consent of the House of Assembly and the Senate of Saint Lucia, and by the authority of the same, as follows:

PRELIMINARY**Short title and commencement**

1.—(1) This Act may be cited as the Universal Health Coverage Act, 2026.

(2) This Act shall come into force on a date to be fixed by the Minister, by Order published in the *Gazette*.

Interpretation**2. In this Act —**

“actuary” means —

- (a) a Fellow by examination of the Institute of Actuaries in England, or the Faculty of Actuaries in Scotland, of the Society of Actuaries in the United States of America or an actuary possessing such other qualifications as may be approved by the Minister; or
- (b) a person recognized by the Minister as having actuarial knowledge and experience;

“Authority” means the Universal Health Coverage Authority established under section 5;

“beneficiary” means a person who has a relationship with an insured person;

“benefit” means a benefit under section 86;

“Board” means the Universal Health Coverage Board under section 8;

“certificate of citizenship” means a —

- (a) a certificate issued under the Citizenship of Saint Lucia Act, Cap. 1.04;
- (b) a certificate issued under the Citizenship by Investment Act, Cap. 1.20;

“certificate of registration” means a certificate of registration issued under section 54;

“Chairperson” means the Chairperson of the Board;

“Chief Executive Officer” means the Chief Executive Officer of the Authority appointed under section 31;

“claim” means a claim for a benefit under Part V;

“committee” means a committee appointed under section 15;

“contribution” means a contribution under sections 71, 72 and 73;

“Deputy Chairperson” means the Deputy Chairperson appointed under section 10;

“employee” has the meaning assigned under the Labour Act, Cap. 16.04;

“employer” has the meaning assigned under the Labour Act, Cap. 16.04;

“Fund” means the Universal Health Coverage Fund established as a special fund under section 22 of the Public Finance Management Act, Cap. 15.01;

“health care provider” —

(a) means a health practitioner that provides with respect to the Plan —

- (i) primary health care,
- (ii) secondary health care, or
- (iii) tertiary health care;

(b) includes —

- (i) an in-network health care provider,
- (ii) an out-of-network health care provider,
- (iii) a primary health care provider,
- (iv) a specialist health care provider,
- (v) an independent health care provider association;

“independent health care provider association” means a group of health care providers organized under a formal structure to contract with the Authority;

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“health practitioner” —

- (a) has the meaning assigned under the Health Practitioners Act, Cap. 11.06;
- (b) includes a nurse practitioner registered under the Registration of Nurses and Midwives Act, Cap. 11.08;

“in-network health care provider” means a health care provider that has a direct or indirect contractual agreement to deliver services to an insured person or beneficiary;

“insurance administrator” means an insurance business that provides insurance under the Plan;

“insurance business” means a company carrying on insurance business under the Insurance Act, Cap. 12.08;

“insured person” means a person registered and insured for a benefit payable under this Act;

“medical treatment” includes medical, surgical or rehabilitative treatment; any course of diet or other regimen; and the supply of medical and surgical appliances;

“Minister” means the Minister responsible for health;

“national insurance card” means a national insurance card numbered and issued to an insured person or beneficiary; or a card substituted for the national insurance card under the National Insurance Corporation Act, Cap. 16.01;

“national insurance number” means the national insurance number assigned to an insured person under the National Insurance Corporation Act, Cap. 16.01;

“out-of-network health care provider” means a health care provider that does not have a direct or indirect contractual relationship with the Authority;

“Plan” means the Universal Health Coverage Plan established under this Act;

“premiums” means the payments made directly or indirectly by beneficiaries, employers, insurance administrators or risk-bearing entities to the Authority or an insurance administrator for the purchase of health care services;

“primary health care provider” means a registered health care provider responsible for delivering primary health care;

“primary health care” means the first level of contact for an individual within the healthcare system, focusing on prevention, health promotion, treatment of common diseases, and management of chronic conditions;

“public-private partnership” means financing and service delivery arrangements between the Government or the Authority and private investors, insurance administrators or health care providers in accordance with the Public Procurement Act, Cap. 15.10;

“Register” means —

- (a) in the case of a registered insurance administrator or registered health care provider, the Register of Registered Insurance Administrators and Registered Health Care Providers under section 61;
- (b) in the case of an insured person or beneficiary, the Register of Insured Persons and Beneficiaries under section 80;

“registered insurance administrator” means an insurance business issued with a certificate of registration;

“registered health care provider” means a health care provider issued with a certificate of registration;

“Registrar of Insurance” means the Registrar of Insurance designated under section 5 of the Insurance Act, Cap. 12.08;

“risk-bearing entity” means an insurer, provider or organization that —

- (a) assumes financial responsibility for the cost of health care services provided to a defined population or group of beneficiaries; and
- (b) bears the risk of financial loss or gain based on the actual cost and performance of care delivered such as value-based or alternative payment arrangements;

“secondary health care” —

- (a) means specialized medical services provided by a health practitioner that typically require a referral from a primary health care provider;
- (b) includes more advanced diagnostics and treatments delivered in facilities, such as hospitals or specialist clinics;

“specialist health care provider” means a health practitioner who has received advanced training in a medical specialty outside of primary care and is authorized to deliver services within that speciality;

“tertiary health care” means highly specialized medical care provided by advanced hospitals or medical centres involving complex treatments, surgeries and procedures for severe or rare conditions, requiring specialized expertise and technology;

“Third Party Administration System” means the Third Party Administration System established by the Authority under section 6(1)(q);

“Tribunal” means the Universal Health Coverage Tribunal established under section 112;

“universal health care” means a healthcare system in which the Government provides to all citizens access to healthcare services regardless of income or social status;

“universal health coverage” means that all individuals and communities have access to the health services needed without suffering financial hardship.

Application and non-application

3.—(1) This Act binds the Crown.

(2) This Act does not apply to —

- (a) the provisions relating to any injury attracting industrial benefit under the National Insurance Corporation Act, Cap. 16.01;

- (b) bodily injury caused to a person arising out of the use of a vehicle on a road attracting coverage under a policy of insurance as required under the Motor Vehicles and Road Traffic Act, Cap. 8.01;
- (c) a complaint made under the Health Services (Complaints and Conciliation) Act, Cap. 11.19; or
- (d) a complaint made under the Insurance Act, Cap. 12.08.

Purposes of this Act

4. The purposes of this Act are —

- (a) to establish the administrative framework and other necessary mechanisms to enable the provision of equitable, accessible, affordable and quality health care services to all persons for the attainment of universal health coverage;
- (b) to facilitate people centred health care that meets the needs of the population;
- (c) to allow a patient to choose a registered insurance administrator and registered health care provider;
- (d) to provide plurality in the health care system with equal opportunity for public and private sector participation;
- (e) to promote efficiency in health care administrative operations; and
- (f) to enable sustainability through appropriate allocation of resources in health care, in collaboration with the Ministry responsible for health.

PART I ADMINISTRATION

Division 1 Universal Health Coverage Authority

Establishment of the Universal Health Coverage Authority

5.—(1) There is established a body to be known as the Universal Health Coverage Authority.

(2) The Authority is a body corporate to which section 19 of the Interpretation Act, Cap. 1.06 applies.

Functions of the Authority

6.—(1) The functions of the Authority are —

- (a) to establish and implement a universal health coverage plan to facilitate the provision of accessible, affordable, equitable and quality health care services to all persons;
- (b) to establish and implement mechanisms for quality assurance in the delivery of universal health coverage, benefits and services under the Plan;
- (c) to promote improved methods and levels of efficiency in the delivery of universal health coverage, benefits and services under the Plan;
- (d) to collaborate with the Registrar of Insurance on the criteria and process for certification by the Registrar of Insurance of a company carrying on an insurance business;
- (e) in consultation with the Ministry responsible for health and other bodies, to establish the criteria for registration of a healthcare provider under the Plan;
- (f) to register all persons to receive benefits under the Plan;
- (g) to register —
 - (i) health practitioners as a health care provider in the Plan, and
 - (ii) an insurance business as an insurance administrator in the Plan;
- (h) to oversee registered health care providers under the Plan in accordance with section 18(4) and publish a list of registered health care providers;
- (i) to set the terms of agreements including setting the rates of payment and establishing the risk adjustment mechanisms with —

- (i) registered insurance administrators,
- (ii) registered health care providers;
- (j) to manage, control and keep under review the Fund and to supervise and control expenditures from the Fund;
- (k) to submit to the Minister a prescribed report on the Plan and policies relating to universal health care;
- (l) to enter a public-private partnership with a registered insurance administrator or registered health care provider;
- (m) to achieve sustainable and affordable universal access to quality health care services by providing for equity and efficiency in financing using the Stratified Pooled Risk Coverage Model;
- (n) to cause a review of the provisions of this Act to be conducted at least once every three years and publish a report with recommendations, if any, to the Minister;
- (o) to be responsible for the administration of the Plan or delegate such responsibility to contracted entities that perform some or all the administrative duties;
- (p) to facilitate and enhance the development of a consolidated system of universal health coverage and an integrated health care delivery system with a focus towards population-based health care principles of value-based health care and manage health care that enhances cost containment;
- (q) to establish the prescribed Third Party Administration System;
- (r) to establish and oversee national standards for health information exchange, interoperability, coding systems, electronic communications and integrated healthcare delivery in collaboration with agencies of the Government and other stakeholders;
- (s) to do or cause to be done such other things as may be conferred by this Act or any other enactment and such

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other things that may enable the Authority to carry out its functions.

(2) The Authority, may in carrying out the functions under this section, consult with and obtain assistance from a ministry, department or statutory body.

(3) For the purposes of subsection (1), the Authority may enter into a Memorandum of Understanding with the ministry, department or statutory body.

(4) In this section —

“population-based health care” —

- (a) means an approach to health care delivery in which services are designed and delivered to improve the health outcomes of a defined population;
- (b) includes preventative, promotive, curative, rehabilitative and coordinated care interventions, with a focus on equity, risk stratification and long-term health improvement;

“Stratified Pooled Risk Coverage Model” means the framework under this Act that comprises —

- (a) the benefits;
- (b) contributions; and
- (c) the payment of the benefits under paragraph (a) with the contributions under paragraph (b);

“value-based health care” means a model of health care delivery in which the value of services is determined by the health outcomes achieved relative to the cost of delivering such outcomes and which emphasizes integrated, patient-centered care, prevention and coordination across the continuum of care.

Powers of the Authority

7.—(1) The powers of the Authority are —

- (a) to establish the benefits to be provided under the Plan;

- (b) to set the payment rate and establish and administer the risk adjustment mechanism for a registered insurance administrator for the benefits under the Plan;
- (c) to fix fee schedules, set payment rates and establish risk adjustment mechanisms for a registered health care provider for the benefits under the Plan;
- (d) to invest the monies of the Fund;
- (e) to appoint officers and such other employees or agents or to outsource and contract administrative services as the Authority considers necessary;
- (f) where necessary, to enter into a public-private partnership with —
 - (i) an in-network health care provider, out-of-network health care provider, independent health care provider association or other bodies for the better administration of the Plan,
 - (ii) a registered insurance administrator for the purposes of managing and administering the benefits under the Plan, and
 - (iii) a registered health care provider for the provision of the benefits under the Plan;
- (g) to utilize the monies received by the Fund to achieve the purposes of this Act;
- (h) to cause on-site inspections of a registered health care provider in accordance with subsection (2);
- (i) to require the production by any person in possession of any information relating to the Plan such information as is necessary or for or in connection with carrying out the purposes of this Act;
- (j) to appoint an actuary to conduct, actuarial projections and reviews and to calculate estimates of per capita costs of the Plan;
- (k) to outsource any power or function on such terms and conditions to be agreed except that where an outsource

expenditure is likely to exceed one per cent of the annual budget of the Fund, such outsourcing is subject to the approval of the Minister; and

- (l) to do or cause to be done, such things as may be conferred by this Act or other enactment and such other things that may enable the Authority to carry out its functions.
- (2) The Authority may for the purposes of subsection (1)(h) —
 - (a) inspect the premises, equipment and any documents, procedures and information technology systems of a registered health care provider;
 - (b) examine the claims, data and accounting records in the possession of a registered health care provider;
 - (c) make enquiries as may be necessary to ascertain whether the provisions of this Act are being complied with in any such premises or place and exercise such other powers as may be necessary for the administration of this Act.

(3) The Authority may pay for the coverage from the registered insurance administrator for individuals that are not able to pay for the services of a registered insurance administrator or be responsible for paying for the levels of care above the first level of benefits.

Board of the Authority

8.—(1) The governing body of the Authority is the Universal Health Coverage Board.

(2) Subject to subsection (3), the Board comprises nine persons, as follows —

- (a) eight persons having experience in —
 - (i) insurance,
 - (ii) healthcare,
 - (iii) business and strategy,
 - (iv) labour,
 - (v) law,

- (vi) technology,
- (vii) communication,
- (viii) civil society;

(b) the Chief Executive Officer as an *ex-officio* member.

(3) The Minister, on the recommendation of Cabinet, shall appoint the members of the Board.

Disqualification

9. A person is disqualified from being a member of the Board and is not eligible to be appointed as a member of the Board, or having been appointed, is not eligible to continue as a member of the Board, if that person —

- (a) is a member of Parliament;
- (b) has filed for bankruptcy in a court or is declared by a court to be a bankrupt;
- (c) is declared by a court to be mentally incapacitated by reason of unsoundness of mind;
- (d) has been convicted of a criminal offence, except if the offence —
 - (i) is a minor traffic offence, or
 - (ii) is spent in accordance with the Criminal Records (Rehabilitation of Offenders) Act, Cap. 3.13.

Chairperson and Deputy Chairperson

10.—(1) The Minister shall appoint the Chairperson and Deputy Chairperson.

(2) The Deputy Chairperson shall act as Chairperson —

- (a) during a vacancy in the office of the Chairperson;
- (b) during all periods when the Chairperson is absent from duty or, for any other reason, is unable to perform the functions of his or her office.

Term of appointment

11.—(1) Subject to this section, the Board is appointed for a term not exceeding five years.

(2) A member of the Board is eligible for reappointment for no more than two consecutive terms and a third term on the recommendation of the Minister.

(3) Notwithstanding this section, the appointment of members of the Board may be staggered in the prescribed manner.

Functions of the Board

12.—(1) The functions of the Board are —

- (a) to achieve the objectives of the Plan in accordance with the policies of the Government;
- (b) to oversee the effective management and provide strategic direction to the Authority;
- (c) to approve the design, beneficiary targeting and partnership decisions for each of the two financing windows, and smooth operation of the Plan;
- (d) to coordinate and synchronize between the eligibility criteria, inclusions and exclusions and operations of the fund based and insurance based financing windows;
- (e) to approve annual business plan, financial plans and annual budget and major transactions for each of the two financing windows;
- (f) to register the companies carrying on insurance business as insurance administrators for execution of the Plan under this Act;
- (g) to enter into contracts with an entity, organization or person for each of the two financing windows;
- (h) to register the health practitioners as health care providers for execution of the Plan under this Act;
- (i) to approve the rates for different services provided through registered health care providers under this Act;
- (j) to perform any other functions assigned under this Act.

(2) In this section —

“financing window” —

(a) means a financing mechanism established under the Plan through which a benefit is financed, administered and paid in accordance with this Act;

(b) includes —

(i) the fund-based financing window, and

(ii) the insurance-based financing window;

“fund-based financing window” means the financing mechanism under the Plan through which the cost of a benefit is financed wholly or primarily from the Fund for eligible persons whose coverage is funded by the Authority in accordance with this Act;

“insurance-based financing window” means the financing mechanism under the Plan through which a benefit is financed through premiums and administered by a registered insurance administrator under this Act in accordance with the terms of registration and any public-private partnership.

Powers of the Board

13.—(1) The Board has the power to do all things necessary or convenient to be done in connection with the performance of the functions under section 12.

(2) Without limiting the generality of subsection (1), the Board has the power at all reasonable times to require —

(a) a registered insurance administrator or registered health care provider to supply such information as the Authority reasonably requires or to produce for examination records that are required to be kept by a registered insurance administrator or registered health care provider;

(b) a beneficiary to supply information required by the Authority for the purpose of enabling the Authority to supply information to perform the functions under section 12;

- (c) an employer to supply information required by the Authority for the purpose of enabling the Authority to perform the functions under section 12;
- (d) a person involved in the regulation of an insurance business or a health practitioner to supply information as the Authority reasonably requires to perform the functions under section 12.

(3) A registered insurance administrator, registered health care provider, beneficiary, employer or person involved in the regulation of an insurance business or a health practitioner shall not fail without reasonable excuse to answer any question relating to any document or any matter when required to do so by the Board under subsection (2).

(4) A person who contravenes subsection (3) commits an offence and is liable on summary conviction to a fine not exceeding five thousand dollars or to a term of imprisonment not exceeding one year to both.

Delegation of functions and powers

14. The Board may, by resolution of a majority of its members, for the purpose of carrying out the functions under section 12 or powers under section 13, delegate, in writing to one or more of its members, a function under section 12 or power under section 13.

Appointment of committees

15.—(1) The Board may, for the purpose of carrying out the functions under section 12, appoint a committee to give advice to the Board on such matters relating to the functions of the Board.

(2) The Board may appoint persons as members of a committee appointed under subsection (1), whether or not an officer or employee of the Authority, for such period as the Board determines.

(3) A committee appointed under subsection (1) shall keep a record of any recommendation it makes to the Board.

(4) The recommendations of a committee established under subsection (1) shall be considered and reviewed by the Board and are not binding on the Board.

(5) Without limiting the generality of subsection (1), the Board may appoint a joint oversight committee comprising of representatives from a ministry, department or statutory body.

Leave of absence

16. The Minister may, on the approval of Cabinet and on the application of a member of the Board in writing, grant leave of absence to the member for a period not exceeding three months.

Resignation

17.—(1) Where a member of the Board becomes disqualified under section 9 that member shall in writing submitted to the Minister, immediately resign from the membership of the Board.

(2) A member of the Board, other than the Chairperson, may for any reason other than disqualification under section 9, resign from the membership of the Board by instrument in writing addressed to the Minister and transmitted through the Chairperson, and from one month after the date of the receipt by the Minister of the instrument that member ceases to be a member of the Board.

(3) The Chairperson may resign his or her office by instrument in writing addressed to the Minister and his or her resignation takes effect one month after the **date** of the receipt of the instrument by the Minister.

Revocation

18. The Minister may, on the recommendation of Cabinet and by written notice, revoke the appointment of a member of the Board if Cabinet is satisfied that the member —

- (a) is disqualified from being a member of the Board under section 9;
- (b) is unable to perform the functions of his or her office;
- (c) commits an act of misconduct under section **24**(4);
- (d) has contravened this Act;
- (e) has failed to attend three consecutive meetings of the Board

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without presenting a medical certificate or without being excused —

- (i) in the case of the Chairperson, by the Minister in writing, or
- (ii) in the case of any other member, by the Chairperson in writing.

Vacancy

19.—(1) The office of a member of the Board is vacated —

- (a) on the death of the member;
- (b) if the member becomes disqualified under section 9;
- (c) if the member resigns under section 17;
- (d) if the Minister revokes the appointment of the member under section 18;
- (e) on the expiry of the term of appointment of the member.

(2) A decision of the Board taken at a meeting is not invalidated by a vacancy in the membership if there is the quorum required under section 23.

Temporary appointment

20.—(1) The Minister may, on the recommendation of Cabinet, appoint a person to act temporarily in place of a member of the Board who —

- (a) has been granted a leave of absence under section 16;
- (b) is absent from Saint Lucia; or
- (c) is unable to perform the functions of his or her office.

(2) A person appointed under subsection (1) shall act —

- (a) for the duration of the absence or inability of the member of the Board; or
- (b) until another person is appointed under section 8.

Meetings

21.—(1) The Board shall meet quarterly or at times as may be necessary or expedient for the transaction of business.

(2) The meetings of the Board must be held at the place and time that the Chairperson determines.

(3) The Chairperson may call a special meeting of the Board within seven days of receipt of a written request for that purpose addressed to the Chairperson by any other member of the Board.

(4) The Chairperson and any other member of the Board is deemed to be present at a meeting of the Board if the Chairperson or other members of the Board participates by telephone, video link or satellite, and all members of the Board participating in the meeting are able to hear and speak to each other.

(5) At a meeting of the Board —

- (a) the Chairperson shall preside;
- (b) if the Chairperson is not present, the Deputy Chairperson shall preside; or
- (c) if the Chairperson or the Deputy Chairperson is not present, the members present shall select the member to preside.

Co-opting

22.—(1) Subject to subsection (2), the Board may co-opt a person to attend a meeting of the Board at which it is proposed to deal with a particular matter, for the purpose of assisting or advising the Board.

(2) A co-opted member of the Board does not have the right to vote.

Quorum

23. A quorum for a meeting of the Board is constituted if at the meeting there is the presence of the Chairperson, Deputy Chairperson or member selected under section 21(5)(c) and four members participating in the meeting.

Declaration of interest and abstention from voting

24.—(1) A member of the Board who has a pecuniary or other interest in a matter before the Board shall declare the nature of his or her interest at the first meeting of the Board at which it is practicable to do so.

(2) Where a member of the Board declares an interest under subsection (1), the member of the Board shall leave the meeting on the matter coming up for discussion and shall not receive other communication on the matter.

(3) A declaration under subsection (1) and the departure of a member of the Board from the meeting under subsection (2) must be noted in the minutes of the meeting.

(4) A member of the Board commits an act of misconduct if he or she —

- (a) contravenes subsection (1);
- (b) votes in respect of a matter before the Board in which he or she has an interest;
- (c) seeks to influence the vote of another member of the Board in relation to a matter before the Board.

(5) Where a person contravenes subsection (1), his or her appointment may be revoked under section 18.

Corporate Secretary

25. —(1) The Board shall appoint a person to be the Corporate Secretary to the Board.

(2) A person is qualified to be appointed under subsection (1) if he or she —

- (a) holds a bachelors degree in law from an accredited university;
- (b) has at least five years experience in a company secretarial, legal or administrative role.

(3) The Corporate Secretary shall —

- (a) record the minutes of each meeting of the Board;

- (b) keep the minutes in a safe place;
- (c) produce the minutes at the next meeting of the Board to be confirmed by the Board;
- (d) submit the minutes at the next meeting of the Board to be confirmed by the Board;
- (e) perform the functions assigned to him or her by the Board and under this Act.

Decisions of the Board

26.—(1) Decisions of the Board shall be taken by a simple majority of votes of members present and voting at the meeting.

(2) The Chairperson has an original vote and in cases of equal division the Chairperson has the casting vote.

(3) In the absence of the Chairperson and in the case of an equal division of votes, the Deputy Chairperson has the casting vote.

Seal

27.—(1) The Authority shall have an official seal.

(2) The seal of the Authority must be affixed in the presence of, and witnessed by —

- (a) the Chairperson or the Deputy Chairperson; and
- (b) the Chief Executive Officer.

Signification of other documents

28. A document, other than a document required by law to be under seal, which is executed by, and a decision of, the Board shall be signed by —

- (a) the Chairperson, Deputy Chairperson or a member of the Board authorized in writing by the Chairperson to act on behalf of the Chairperson; and
- (b) the Chief Executive Officer.

Board to regulate its own procedure

29.—(1) Subject to this Act, the Board shall regulate its own procedures.

(2) The Board may make Rules for —

- (a) the proper conduct of its affairs;
- (b) the maintenance of records including minutes and resolutions;
- (c) governance training for members of the Board;
- (d) the implementation of this Act;
- (e) any other matter which the Board considers necessary for the effective implementation of this Act.

(3) Where the Board makes Rules under subsection (2), the Minister may, on the advice of the Board publish the Rules as a statutory instrument in the *Gazette*.

Remuneration

30. The members of the Board shall be paid such remuneration as determined by Cabinet.

*Division 2**Chief Executive Officer and Staff of the Authority***Appointment of Chief Executive Officer**

31.—(1) The Board may appoint, on terms and conditions as the Board determines, a Chief Executive Officer.

(2) In the absence of the Chief Executive Officer, the Board may appoint a person to act as the Chief Executive Officer during the period of absence on terms and conditions as the Board determines.

(3) Notwithstanding subsection (1), the Chief Executive Officer shall not serve more than the terms determined by the Board for continuity and performance of the Board.

Functions of the Chief Executive Officer

32.—(1) The function of the Chief Executive Officer is to manage the daily affairs of the Authority.

(2) Without limiting the generality of subsection (1), the functions of the Chief Executive Officer are —

- (a) to manage the staff of the Authority;
- (b) to administer the Fund;
- (c) to assess contributions under this Act for collection and payment into the Fund;
- (d) to pay out of the Fund of the benefits under this Act and of the expenditure necessary for the proper administration of the Fund;
- (e) to account for all moneys collected, paid or invested under this Act;
- (f) to invest surplus monies in the Fund as directed by the Board.

(3) The Chief Executive Officer shall exercise all the functions entrusted to him or her under this Act and be present at all meetings of the Board unless he or she —

- (a) is directed by the Chairperson to withdraw from a meeting;
- (b) has obtained a leave of absence from the Chairperson; or
- (c) is incapacitated by illness or other cause from attending a meeting.

(4) The Chief Executive Officer may, for the purpose of carrying out his or her functions under this section, delegate, in writing to one or more staff of the Authority, a function specified under subsection (1) or (2).

(5) The Chief Executive Officer is not authorized to delegate a power to delegate under subsection (4).

Staff of the Authority

33.—(1) The Chief Executive Officer shall employ, on terms and conditions as may be approved by the Board, staff of the Authority for the performance of the functions and powers of the Authority.

(2) Staff employed under subsection (1) shall perform the duties assigned to him or her under this Act and by the Chief Executive Officer.

(3) The Authority may appoint suitably qualified and experienced persons as inspectors to carry out an inspection on its behalf.

(4) An inspector appointed under subsection (3) —

- (a) shall, if requested, produce evidence of his or her appointment;
- (b) shall, after completion of an inspection compile a report including his or her recommendations to the registered insurance administrator or registered health care provider for compliance where applicable and a copy of such recommendations shall be forwarded to the registered insurance administrator or registered health care provider; and
- (c) may request the assistance of a police officer in carrying out his or her functions.

*Division 3**Finances of the Authority***Revenue of the Authority**

34. The revenue of the Authority comprises —

- (a) monies raised by the Authority in the form of donations, loans, grants, investments or other lawful means;
- (b) sums allocated to the Authority by Parliament;
- (c) fees charged and collected under this Act;
- (d) monies payable to the Authority under another enactment; and

- (e) other sums that may become payable or vested in the Authority in respect of matters incidental to its functions and powers.

Management of finances and application of revenue

35.—(1) Part XIII of the Public Finance Management Act, Cap. 15.01 applies to the Board in relation to finance management.

(2) The revenue of the Authority in a financial year may be applied to the payment of —

- (a) interest and other charges on, and the repayment of, a loan payable by the Authority;
- (b) remuneration payable under this Act; and
- (c) expenses incurred by the Authority in the discharge of its functions under this Act.

Borrowing, lending, guaranteeing and other contingent liabilities

36.—(1) The Board may, with the approval of the Minister responsible for finance, borrow money from the Government or a financial institution by way of a loan, overdraft or otherwise on the terms with respect to the borrowing, issue, transfer and interest as the Minister responsible for finance approves, for —

- (a) the provision of working capital or additional working capital; and
- (b) the performance of the functions of the Board under this Act.

(2) The Minister responsible for finance may, with the approval of Parliament, guarantee in the manner and on conditions as he or she thinks fit, the payments of the principal and interest of an authorized borrowing by the Authority.

(3) Where the Minister responsible for finance is satisfied that there has been default in the payment of principal money or interest guaranteed under this section, he or she shall direct the repayment out of the Consolidated Fund for the amount in respect of which there has been such default.

Estimates of revenue and expenditure

37.—(1) The Board shall submit to the Minister its estimates of revenue and expenditure in a form the Minister directs.

(2) In accordance with section 78(1)(e) of the Public Finance Management Act, Cap. 15.01, the Board shall submit estimates of revenue and expenditure for two subsequent financial years for the approval of the Minister responsible for finance.

Strategic, financial, operational and business plan

38. In accordance with section 82 of the Public Finance Management Act, Cap. 15.01, the Board shall submit to the Minister and the Minister responsible for finance —

- (a) a three year strategic plan reflecting the strategic objectives of the Board over the financial year and two subsequent financial years; and
- (b) no later than four months before the beginning of a financial year, a financial, operational or business plan reflecting proposals to operationalize the strategic objectives of the Board over the financial year.

Accounts and audit

39.—(1) In accordance with section 83 of the Public Finance Management Act, Cap. 15.01, the Board shall make a report to the Minister and the Minister responsible for finance on its financial operations quarterly and at such other time specified by the Minister or the Minister responsible for finance in relation to its approved business plan for the financial year.

(2) The Board shall within three months after the end of each financial year have its accounts audited by an independent auditor appointed by the Board who shall conduct the audit in accordance with generally accepted international auditing standards and provide the Board with an audited financial statement and a report on the financial statement.

(3) A member of the Board, the Chief Executive Officer, and staff of the Authority shall grant to the auditor appointed under subsection

(2), access to books, deeds, contracts, accounts, vouchers, or other documents which the auditor considers necessary.

(4) An auditor may require a member of the Board, the Chief Executive Officer or staff of the Authority to appear, make a signed statement or provide information in relation to the books, deed, contracts, accounts, vouchers, or other documents as the auditor considers necessary.

(5) Where a member of the Board, the Chief Executive Officer or staff of the Board contravenes subsection (3) —

- (a) in the case of a member of the Board, his or her appointment may be revoked;
- (b) in the case of the Chief Executive Officer, his or her appointment may be terminated;
- (c) in the case of staff of the Authority, his or her employment may be terminated.

Quarterly and annual reports

40.—(1) The Board shall submit to the Minister —

- (a) a quarterly report including —
 - (i) the number of applications received for registration of insurance administrators, health care providers, an insured person, employer or employee,
 - (ii) the number of applications granted for registration of insurance administrators, health care providers, an insured person, employer or employee,
 - (iii) the list of registered insurance administrators and registered health care providers,
 - (iv) a response to a request made by the Minister;
- (b) subject to subsection (2) and not later than six months after the end of each financial year, an annual report on the operations and activities and transactions of the Board containing an account of the performance of the activities and operations of the Board.

(2) An annual report under subsection (1)(b) must be accompanied by the auditor's report under section 39.

(3) The Minister shall submit the annual report and auditor's report submitted under subsection (1)(b) to be laid in Parliament within twenty-eight days of its receipt by the Minister, or if Parliament is not in session, within twenty-eight days of the next session of Parliament.

Division 4
General

Oath or affirmation of secrecy and confidentiality

41.—(1) A member of the Board or committee and staff of the Authority is required to take the prescribed oath or affirmation of secrecy.

(2) Subject to subsection (3), a member of the Board or committee and staff of the Authority —

- (a) shall preserve the confidentiality with respect to matters coming to his or her knowledge in the performance of his or her duties;
- (b) shall not disclose to another person information that a member of the Board or committee or staff of the Authority has acquired in the course of his or her duties or in the exercise of the functions of the Authority, Board or committee under this Act or any other law relating to —
 - (i) the business affairs of the Authority, Board or committee,
 - (ii) the affairs of a business, partnership business, staff or a member of the Board or committee;
- (c) shall not permit a person to have access to records in the possession, custody or control of the Authority, Board or committee.

(3) Subsection (2) does not apply to disclosure —

- (a) in respect of the affairs of a member of the Board or committee, a business or a partnership business, with the consent of the member of the Board or committee, a

business or partnership business, which consent has been given voluntarily;

- (b) for the purpose of enabling or assisting the Authority, Board or committee in exercising a function conferred on it under this Act or other enactment;
- (c) if the information disclosed is or has been available to the public from another source;
- (d) if the information disclosed is in a summary or in statistics expressed in a manner that does not enable the identify of a business, partnership business or member of the Board or committee to which the information relates, to be ascertained;
- (e) lawfully made to a person with a view to the institution of, or for the purpose of —
 - (i) criminal proceedings,
 - (ii) disciplinary proceedings relating to the discharge of the duties by a member of the Board or committee or staff of the Authority, or
 - (iii) legal proceedings pursuant to a court order.
- (4) Where staff of the Authority or a member of the Board or committee contravenes subsection (2) —
 - (a) in the case of staff of the Authority, his or her employment may be terminated;
 - (b) in the case of a member of the Board or committee, his or her appointment may be revoked under section 20.

Protection from liability

42.—(1) An action or other proceedings shall not lie against a member of the Board, or staff of the Authority in respect of an act done or omitted to be done in good faith in the exercise or purported exercise of his or her functions under this Act except in cases of personal injury.

(2) The Authority shall indemnify a member of the Board or staff of the Authority for the legal cost of defending an action or other proceedings.

PART II UNIVERSAL HEALTH COVERAGE PLAN

Division 1 Universal Health Coverage Plan

Universal Health Coverage Plan

43. There is established a Universal Health Coverage Plan.

Purpose of the Plan

44. The purpose of the Plan is to provide universal access to quality insured health care services under this Act.

Division 2 Registration of Insurance Administrators and Health Care Providers

Requirement for registration of insurance business

45.—(1) A company shall not carry on long-term insurance business for sickness or insurance in accordance with the Insurance Act, Cap. 12.08 under the Plan unless that company is registered as an insurance administrator under this Act.

(2) A company that contravenes subsection (1) commits an offence and is liable on summary conviction to a fine not exceeding twenty-five thousand dollars.

Authority to serve as insurance administrator

46. Notwithstanding section 44, the Authority may serve as the insurance administrator if the private market is unable to provide adequate coverage in alignment with the purpose of the Plan and is deemed to be a registered insurance administrator.

Application for registration as insurance administrator

47.—(1) A company that carries on a long-term insurance business for sickness or insurance under the Insurance Act, Cap. 12.08 may

make an application in the prescribed form to the Authority to be registered under the Plan as an insurance administrator.

(2) An application under subsection (1) must be accompanied by —

- (a) the prescribed application fee;
- (b) a valid certificate issued under the Insurance Act, Cap. 12.08;
- (c) two copies of the constitution, by-laws or rules intended to govern the operation of the insurance business;
- (d) the names, and particular of members of the governing body of the insurance business;
- (e) the persons proposed to manage or administer the insurance business;
- (f) a statement of the minimum number of persons to be covered by the long-term insurance for sickness or insurance;
- (g) the proposed registered healthcare providers available or to be used by the insurance business;
- (h) the healthcare benefits available from the insurance business;
- (i) the proposed minimum contribution for membership;
- (j) evidence of the availability of any minimum financial security, where applicable, required in respect of the long-term insurance for sickness or insurance;
- (k) other prescribed information that the Authority considers necessary to determine the application.

Determination of application for registration as insurance administrator

48.—(1) The Authority may grant or refuse to grant an application for registration.

(2) Without limiting the generality of subsection (1), the Authority may grant an application for registration —

- (a) if there are officers qualified to manage and administer the insurance business;
 - (b) the insurance business complies with the requirements of this Act and other enactments.
- (3) Without limiting the generality of subsection (1), the Authority may refuse an application for registration —
- (a) if the insurance business does not have a valid certificate issued under the Insurance Act, Cap. 12.08;
 - (b) does not carry on a long-term insurance business for sickness.

Categories of registration for health care providers

49.—(1) The categories of registration for a health care provider are —

- (a) individual comprising of a single health practitioner;
- (b) group comprising of practices considered to be a group or a clinic organization;
- (c) delegated credentialing agreement comprising of hospitals or large networks of more than ten health practitioners;
- (d) ancillary or facility including pharmacies, labs, imaging centers and therapy unit.

(2) The Minister may, by Order published in the *Gazette*, add or delete a category of registration specified under subsection (1).

Requirement for registration as health care provider

50.—(1) A health practitioner shall not provide a health care service under the Plan unless that health care provider is registered as a health care provider under this Act.

(2) A health practitioner that contravenes subsection (1) commits an offence and is liable on summary conviction to a fine not exceeding twenty-five thousand dollars.

Application for registration as health care provider

51.—(1) A health practitioner may make an application in the prescribed form to the Authority to be registered as a health care provider under the Plan.

(2) An application under subsection (1) must —

(a) specify —

- (i) the name and contact information of the health care provider,
- (ii) the category of registration to which the application relates,
- (iii) the areas of specialized health expertise,
- (iv) the clinical service proficiency of the health practitioner,
- (v) the address of the health practitioner,
- (vi) the national insurance number and taxpayer identification of the health practitioner;

(b) be accompanied by —

- (i) the prescribed application fee,
- (ii) a valid certificate and licence issued under the Health Practitioners Act, Cap. 11.06,
- (iii) a valid certificate issued under the Registration of Nurses and Midwives Act, Cap. 11.08.

Determination of application for registration of health care provider

52.—(1) The Board may grant or refuse to grant approval of registration of a health care provider.

(2) Without limiting the generality of subsection (1), the Board may grant approval of registration as a health care provider if the health practitioner submits —

- (a) a valid certificate and licence issued under the Health Practitioners Act, Cap. 11.06;

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- (b) a valid certificate issued under the Registration of Nurses and Midwives Act, Cap. 11.08;
- (c) evidence of education, residency and training for the scope of practice;
- (d) proof of continuing professional development, if applicable;
- (e) proof of adequate facility standards and infection control;
- (f) evidence of malpractice coverage;
- (g) validated history of good standing and screening of gross negligence, ethical violation or fraud.

(3) Before granting approval of registration as a health care provider, the Board may inspect the premises of a health practitioner.

(4) Without limiting the generality of subsection (1), the Board may refuse to grant approval of registration of as a health care provider if —

- (a) the health practitioner is not registered or licensed under the Health Practitioners Act, Cap. 11.06 or Registration of Nurses and Midwives Act, Cap. 11.08;
- (b) there is a complaint against the health care provider under the Health Services (Complaints and Conciliation) Act, Cap. 11.19;
- (c) the health care provider does not comply with the requirements under this Act.

Refusal to grant approval of application

53.—(1) Where the Board refuses to grant approval of an application under section 50 the Board shall before refusing an application give the company carrying on insurance business or health practitioner the opportunity of being heard by the Board.

(2) After hearing the person under subsection (1) and making a decision to refuse the application, the Board shall, by written notice to the insurance business or health care provider give the reasons for the refusal of the application.

Certificate of registration

54.—(1) Where the Board grants approval of an application for registration under section 52, the Board shall issue a certificate of registration to —

- (a) in the case of a company carrying on insurance business, as an insurance administrator;
- (b) in the case of a health practitioner, as a health care provider in a category of registration under section 49.

(2) A certificate of registration under subsection (1) must be —

- (a) in the prescribed form;
- (b) accompanied by the prescribed registration fee.

Public-private partnership

55.—(1) On the issue of a certificate of registration, the Authority may enter into a public-private partnership with —

- (a) a registered insurance administrator for management and administration services at prescribed rates in respect of the Plan, on such terms as may be stipulated by the Authority;
- (b) a registered health care provider for the provision of benefits to beneficiaries under the Plan on such terms as stipulated by the Authority.

(2) A public-private partnership, must at a minimum, contain provisions which state —

- (a) the procedure to be followed by which beneficiaries access services from the registered insurance administrator or registered health care provider; including the referral process;
- (b) the benefits to be provided to beneficiaries and the prescribed payment rates for the benefits;
- (c) the services to be provided by the registered insurance administrator or registered health care provider and the prescribed payment rates for the services;

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- (d) any health care quality expectations and standards;
- (e) the procedure for the processing and management of claims;
- (f) the terms of payment for services;
- (g) any financial and clinical audit functions to be conducted;
- (h) the terms and conditions of the public-private partnership between the registered insurance administrator or registered health care provider; and
- (i) the general responsibilities of the parties.

(3) Subject to subsection (2), a public-private partnership between the Authority and a registered insurance administrator may provide that —

- (a) a guaranteed issue applies to all beneficiaries who select or are assigned to a registered insurance administrator;
- (b) a guaranteed renewal applies to all beneficiaries who select or are assigned to a registered insurance administrator;
- (c) a beneficiary is not excluded from receiving benefits due to a pre-existing medical condition; and
- (d) a beneficiary is not precluded or denied access to benefits by a registered insurance administrator without good reason.

Renewal of certificate

56.—(1) An application for renewal of a certificate of registration may be made to the Board by a registered insurance administrator or registered health care provider.

(2) An application for renewal of a certificate of registration under subsection (1) must —

- (a) be in the prescribed form;
- (b) be accompanied by —
 - (i) a copy of the previously issued certificate,
 - (ii) the prescribed renewal fee, and

- (iii) any other document required by the Board for processing an application for the renewal of a certificate of registration.

False statements and forgery

57.—(1) A person shall not forge or change any information on a certificate of registration.

(2) A person who contravenes subsection (1) commits an offence and is liable on summary conviction to a fine not exceeding ten thousand dollars or to imprisonment for a term not exceeding two years.

Suspension of certificate of registration

58.—(1) Subject to subsections (2) and (3), the Board may suspend a certificate of registration if a registered insurance administrator or registered health care provider fails to comply with a condition of the certificate of registration.

(2) The Board may suspend a certificate of registration for a period not exceeding three years if the Board thinks fit.

(3) The Board shall, before suspending a certificate of registration under subsection (1) —

- (a) cause a written notice to be served on the registered insurance administrator or registered health care provider to take action within a period specified in the notice;
- (b) give the registered insurance administrator or registered health care provider an opportunity to make representations in writing to the Board, including the reasons that the Board must not suspend the certificate of registration.

(4) Where the Board suspends a certificate of registration under subsection (1), the Board shall —

- (a) give the registered insurance administrator or registered health care provider notice in writing of the suspension;
- (b) provide the reasons for the suspension; and
- (c) inform the registered insurance administrator or registered health care provider of Part VIII.

(5) Where the Board suspends a certificate of registration under subsection (1), the certificate of registration ceases to have effect for the period of the suspension.

(6) The Board shall publish a notice of the suspension of a certificate in the *Gazette* no later than fourteen days after a decision to suspend the certificate of registration is made.

(7) On suspension of a certificate of registration under subsection (1), the Board may require a registered insurance administrator or registered health care provider to surrender the certificate of registration to the Board for the period of the suspension.

(8) A registered insurance administrator or registered health care provider that contravenes subsection (7) commits an offence and is liable on summary conviction to a fine not exceeding ten thousand dollars.

Termination of suspension

59. Where the Board suspends a certificate section 58, the Board may, for reasons the Board considers sufficient, terminate the suspension in whole or in part.

Revocation of certificate of registration

60.—(1) Subject to subsections (2) and (3), the Board may revoke a certificate of registration if a registered insurance administrator or registered health care provider —

- (a) has an order in bankruptcy made against the registered insurance administrator or registered health care provider which remains undischarged;
- (b) has been convicted of a criminal offence under this Act or any other enactment of an offence involving fraud or dishonesty except —
 - (i) a minor traffic offence,
 - (ii) an offence that is spent in accordance with the Criminal Records (Rehabilitation of Offenders) Act, Cap. 3.13;
- (c) has committed misconduct;

- (d) has procured a certificate under this Act as a result of a misleading, false or fraudulent representation;
- (e) fails to rectify the issue giving rise to a suspension of the certificate under section 58 by the end of the period of suspension;
- (f) in the case of an individual, is deceased;
- (g) in the case of a company, is wound up.

(2) The Board shall, before revoking a certificate of registration under subsection (1), give the registered insurance administrator or registered health care provider an opportunity to make representations in writing to the Board.

(3) Where the Board revokes a certificate of registration under subsection (1), the Board shall —

- (a) give the registered insurance administrator or registered health care provider notice in writing of the revocation;
- (b) provide the reasons for the revocation; and
- (c) inform the registered insurance administrator or registered health care provider of Part VIII.

(4) Where a certificate of registration is revoked under subsection (1), a company carrying on insurance business under the Insurance Act, Cap. 12.08 or health practitioner shall make a new application for a certificate of registration under this Act.

(5) Notwithstanding subsection (4), where the Board revokes a certificate of registration under subsection (1), the Board may fix a time before which a company carrying on insurance business under the Insurance Act, Cap. 12.08 is not eligible to make a new application for the certificate of registration.

(6) The Board shall publish the revocation of a certificate of registration in the *Gazette* no later than fourteen days after a decision to revoke is made.

(7) Where a certificate of registration is revoked under subsection (1), the Board may in writing require the company carrying on insurance business under the Insurance Act, Cap. 12.08 or health practitioner to immediately return the certificate of registration to the Board.

(8) A company carrying on insurance business under the Insurance Act, Cap. 12.08 or health practitioner who contravenes subsection (7) commits an offence and is liable on summary conviction to a fine not exceeding ten thousand dollars.

Register of Registered Insurance Administrators and Registered Health Care Providers

61.—(1) The Authority shall keep and maintain a register to be known as the Register of Registered Insurance Administrator and Registered Health Providers.

(2) On registration of a company carrying on insurance business or health practitioner in accordance with this Act, the Authority shall enter the name of the registered insurance administrator or registered health care provider in the Register.

(3) The Authority shall record the following information in the Register in relation to each registered insurance administrator or registered health care provider under this Act —

- (a) name and business address;
- (b) telephone number and electronic mail address;
- (c) qualifications, if applicable;
- (d) the date of registration including the category of registration, if applicable;
- (e) the conditions to which the registration is subject, in accordance with this Act;
- (f) the period of suspension of a certificate;
- (g) the removal from the Register;
- (h) the restoration to the Register;
- (i) other prescribed information that the Board considers necessary.

(4) The Register under subsection (1) may be kept in electronic form.

(5) The Register must at all reasonable times be open to inspection by the public at the office of the Authority or by electronic means and

a search may be effected and extracts of the Register may be obtained by the public on payment of the prescribed fee.

(6) The Authority may make alterations in the Register in relation to the registered insurance administrator or registered health care provider as are necessary.

(7) The Authority shall cause to be published in the Gazette in the month of February in each year an alphabetical list of persons who have at the 31st day of January in that year been registered under this section.

Removal from Register

62.—(1) The Authority may remove from the Register, the name of a registered insurance administrator or registered health care provider if the registered insurance administrator or registered health care provider —

- (a) contravenes a condition of registration under this Act;
- (b) fails to comply with a requirement made of the registered insurance administrator or registered health care provider.

(2) The removal of the name of a registered insurance administrator or registered health care provider from the Register signifies the revocation of registration in accordance with this Act.

(3) The Authority shall remove from the Register the name of a registered insurance administrator or registered health care provider —

- (a) in the case of an individual, who dies;
- (b) in the case of a company, is wound up or dissolved;
- (c) who requests in writing that the Board removes the name from the Register;
- (d) in respect of whom the Board has made a decision to revoke registration;
- (e) who has been registered by reason of a false or misleading statement or declaration;

- (f) that fails to pay a fee under this Act by the due date specified by the Board.

(4) The Authority shall not remove the name of a registered insurance administrator or registered health care provider from the Register under subsection (1) or (3)(d) or (e) without first giving the registered insurance administrator or registered health care provider a reasonable opportunity to be heard.

(5) If, except in the case of subsection (3)(a), the Authority removes the name of a registered insurance administrator or registered health care provider from the Register under this section, the Authority shall immediately give the registered insurance administrator or registered health care provider notice in writing of the removal.

(6) A notice under subsection (5) must —

- (a) specify the reasons for the removal;
- (b) inform the registered insurance administrator or registered health care provider of his or her right of appeal;
- (c) be served personally on, or delivered by post to, the registered insurance administrator or registered health care provider.

(7) On notice being served or delivered, a company carrying on insurance business or health practitioner ceases to be a registered insurance administrator or registered health care provider.

(8) Where the Authority removes the name of a registered insurance administrator or registered health care provider from the Register, the Authority may require that a specified period elapses or that a specified condition be fulfilled before the company carrying on insurance business or health practitioner may re-apply to be registered.

(9) The Authority shall cause to be published in the *Gazette* in the month of February in each year an alphabetical list of persons who have at the 31st day of January in that year been removed from the Register under this section.

*Division 3**Responsibilities of Registered Insurance Administrator or Registered Health Care Provider***Responsibilities of registered insurance administrator**

63. The responsibilities of a registered insurance administrator are —

- (a) to manage and administer the benefits under the Plan for beneficiaries who have chosen or who have been assigned to that registered insurance administrator;
- (b) to provide beneficiaries with access to the benefits included in the Plan;
- (c) to reimburse the Third Party Administration System of the Authority —
 - (i) for payments on service made to a registered health care provider for covered benefits that is the responsibility of the registered insurance administrator,
 - (ii) for the payments under subparagraph (i) made under the Plan at the prescribed rates including any administrative fees payable under the arrangement between the Authority and the registered insurance administrator and the registered insurance administrator,
 - (iii) for the pre-negotiated prescribed monthly payments on the prescribed percentage of premiums that the Authority receives from premiums collected from the beneficiaries or employers or unions or self-funded arrangements;
- (d) to delegate the processing of beneficiary claims from a registered health care provider to the central Third Party Administration System of the Authority and under a public-private partnership between the registered insurance administrator and the Authority, rules of engagement must be set that are associated with prior authorization and eligibility for referrals where necessary and appropriate;

- (e) to delegate the functions of patient steerage, triage, case management and care coordination to the Third Party Administration System of the Authority to conduct case management to improve health outcomes in a cost effective manner as stipulated in the public-private partnership between the registered insurance administrator and the Authority;
- (f) to delegate programmes for health promotion and prevention to the Third Party Administration System of the Authority as stipulated in the public-private partnership between the registered insurance administrator and the Authority;
- (g) to monitor the provision of health care benefits in accordance with quality assurance and standards of care and any Regulations;
- (h) to submit such information in relation to the Plan, as may be requested by the Authority or the Registrar of Insurance; and
- (i) to do or cause to be done such other things as are necessary or expedient for or in connection with carrying out the purposes of this Act.

Responsibilities of registered health care provider

64. The responsibilities of a health care provider are —

- (a) to provide benefits to beneficiaries under the Plan;
- (b) to provide information as the Authority, a registered insurance administrator or registered health care provider requires; and
- (c) to carry out other prescribed responsibilities.

Quality of care

65.—(1) The Authority shall require a registered health care provider to implement policies and procedures that assure the prescribed quality of care, utilization review and technology assessment and to meet the threshold for reimbursement so that —

- (a) the quality of health care services delivered is of a high standard;
- (b) access to benefits is suitable, equitable and standardized;
- (c) the use of medical technology and equipment is consistent with needs and standards of medical practice under the Plan;
- (d) benefits are appropriate and necessary and comply with accepted medical practice and ethics;
- (e) pay-for-performance incentives promotes quality and good outcomes;
- (f) appropriate reporting of diseases and treatments are administered utilizing a coding system as stipulated by the Authority.

(2) The Authority may issue protocols prescribing the quality of care to be maintained by a health care provider.

Display of certificate of registration

66. A registered insurance administrator or registered health care provider shall display the certificate of registration in a conspicuous place on the premises of the registered insurance administrator or registered health care provider.

Duty to submit reports

67.—(1) A registered insurance administrator or a registered health care provider shall submit a report in the prescribed form to the Authority with respect to —

- (a) in the case of the registered insurance administrator, the administration and management of the registered insurance administrator, registered health care provider and beneficiary with data necessary for actuarial analysis, quality management, utilization review and in the assessment of the overall universal health coverage;
- (b) in the case of the registered health care provider, the health care services provided and disease conditions with appropriate codes utilizing the coding system

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stipulated by the Authority under section 65(1)(f) and beneficiary health outcomes and satisfaction reports.

(2) A report under subsection (1) may contain details on —

- (a) financial data;
- (b) utilization data;
- (c) beneficiary health outcome data;
- (d) beneficiary and health care provider satisfaction survey data;
- (e) specific quality and performance data; and
- (f) other prescribed data as may be considered necessary and requested by the Authority.

Maintenance of records

68. A registered insurance administrator or a registered health care provider shall in the prescribed manner maintain and keep records relating to —

- (a) the benefits provided under the Plan;
- (b) all claims under the Plan, where applicable;
- (c) financial records related to the Plan;
- (d) the performance standards as required by the Authority; and
- (e) other prescribed information the Authority requires.

Termination of registered insurance administrator or registered health care provider

69.—(1) The Authority may terminate a registered insurance administrator in the Plan, if the registered insurance administrator —

- (a) commits an act of fraud or misrepresentation in relation to the Plan;
- (b) fails to disclose material information requested by the Authority;
- (c) fails to meet quality assurance requirements;

- (d) without good reason fails to provide benefits to a beneficiary;
- (e) discloses confidential data or fails to protect confidential data;
- (f) does an act or omission that results in the revocation or suspension of his or her certificate with the Registrar of Insurance; or
- (g) breaches a material term of the agreement and notification of the breach must be forwarded immediately to the Registrar of Insurance;
- (h) if the registered insurance administrator is not able to perform in accordance with the standards set by the Authority as it relates to financial responsibility, meeting member's needs, not reimbursing the Authority for payments made where the insurance administrator is responsible for such payments.

(2) The Authority may terminate a registered health care provider in the Plan, if the registered health care provider —

- (a) submits a false or fraudulent claim;
- (b) commits an act of fraud in relation to the Plan;
- (c) fails to disclose material information requested by the Authority;
- (d) fails to comply with a recommendation of an inspector under section 33(4)(b);
- (e) discloses confidential data or fails to protect confidential data;
- (f) fails to meet quality assurance or standards of care requirement;
- (g) without good reason, fails to provide benefits to a beneficiary;
- (h) does an act or omission that results in the revocation or suspension of the certificate of registration.

(3) The Authority may terminate the participation of a registered insurance administrator or a registered health care provider in accordance with a public-private partnership —

- (a) in the interest or public health or safety; or
- (b) for breach of a material term of the agreement.

Withdrawal

70. A registered insurance administrator or a registered health care provider may withdraw from participation in the Plan by giving the Authority ninety days written notice of the intention to withdraw participation in the Plan in accordance with the public-private partnership made under this Act and the public-private partnership must provide for transition of care of beneficiaries as set out in the public-private partnership or as prescribed.

Division 4 *Contributions*

Contribution for Tier 1 benefits

71.—(1) The Government shall contribute to the Plan for Tier 1 benefits.

(2) The contribution under subsection (1) covers all citizens who received Tier 1 benefits up to the prescribed limit as specified in the estimates of revenue and Appropriation law.

(3) Notwithstanding this section, a patient may make co-payments in the prescribed amount at the registered health care provider.

Contribution for Tier 2 benefits

72.—(1) A contribution for Tier 2 benefits may be made —

- (a) by a registered insurance administrator through premiums;
- (b) by a patient who co-pays in the prescribed amount, if required;
- (c) by the Government through means testing;
- (d) by an uninsured person who must pay out-of-pocket.

(2) For the purposes of subsection (1)(c), the Authority shall collect data from households for the purposes of conducting means testing.

(3) In collecting data under subsection (2), the Authority shall use the means testing developed by the Ministry responsible for health in collaboration with the Ministry responsible for equity.

(4) The data collected from households must be based on socioeconomic aspects including —

- (a) housing characteristics;
- (b) access to basic services;
- (c) household composition and characteristics; and
- (d) other prescribed socioeconomic aspects.

(5) The data collected must be used to determine and estimate the household income for the purposes of the payment of premiums.

(6) The Authority shall conduct periodic means testing reviews on households whose income is not derived from salaried employment and on households in need of financial assistance.

(7) In this section, “means testing” means the process by which the Authority determines the ability of individuals or households to pay contributions.

Contribution for Tier 3 benefits

73. A contribution for Tier 3 benefits may be made by —

- (a) re-insurance pools by sharing risks among insurers, Government and international re-insurers;
- (b) the Government for low-income individuals;
- (c) a registered insurance administrator through cost-sharing between the registered insurance administrator, the Government and re-insurers;
- (d) an uninsured person with means by reimbursing the Authority for costs advanced for care for a public health care service but not for a private health care service.

Exemptions from contributions

74.—(1) A contribution must not be made by the following persons who are exempt from making a contribution —

- (a) an employer in respect of an employee for periods —
 - (i) of incapacity for work,
 - (ii) of full-time unpaid apprenticeship, or
 - (iii) other prescribed categories;
- (b) a person who is —
 - (i) a low-income individual,
 - (ii) from a family that falls below the prescribed poverty threshold;
- (c) a vulnerable person such as a person with disabilities and the elderly;
- (d) a retired person;
- (e) a person in lawful custody.

(2) Contributions for persons exempted under subsection (1) must be made from the Consolidated Fund.

(3) A reference to a person in lawful custody under subsection (1)(e) includes an inmate, child in conflict with the law or other person in police custody.

(4) The Minister may, by Order published in the *Gazette*, add to the list of persons exempted from making a contribution under subsection (1).

PART III
INSURED PERSONS AND TRAVEL INSURANCE FOR HEALTH
COVERAGE

Insured person under the Plan

75.—(1) A person is an insured person under the Plan if that person is —

- (a) a citizen of Saint Lucia or ordinarily resident in Saint Lucia or lawfully residing in Saint Lucia for a

period of not less than six months immediately before registration;

- (b) a person on whose behalf contributions are made;
- (c) an employee or employer in the public or private sector;
- (d) a citizen of Saint Lucia residing or working outside of Saint Lucia.

(2) The Minister may, by Order published in the *Gazette*, add to the persons listed under subsection (1) to be an insured person.

(3) An Order made under subsection (2) is subject to an affirmative resolution of Parliament.

(4) Subsection (1) does not apply if a person is employed by an international organization under the International Organizations and Overseas Countries (Immunities and Privileges) Act, Cap. 10.07.

(4) In this section, “ordinarily resident” means that the ordinary residence of a person is not interrupted by reason of the fact that the person is occasionally or temporarily absent from Saint Lucia because of his or her —

- (a) occupation or employment, or that his or her spouse, or if a minor, his or her parent or legal guardian, is in the public service or any embassy, high commission or any other agency of the Government or any international organization to which Saint Lucia is accredited and that occupation or employment requires him or her, his or her spouse or, if a minor, his or her parent or legal guardian to travel outside of Saint Lucia; or
- (b) in pursuit of a *bona fide* full-time programme of study, or such pursuit by his or her spouse, or if a minor, his or her parent or legal guardian and such a programme involves occasional or regular residence outside of Saint Lucia.

Application for registration under the Plan

76.—(1) An insured person may make an application to the Authority to be registered under the Plan.

(2) An application under subsection (1) —

- (a) must be in the prescribed form;
- (b) must be accompanied by —
 - (i) a valid national insurance card,
 - (ii) in the case of a citizen, a national identification document including a birth certificate, national identification card, passport or certificate of citizenship;
- (c) must contain —
 - (i) the name of the selected registered health care provider,
 - (ii) the name of the selected registered insurance administrator,
 - (iii) the name of other beneficiaries and be accompanied by the documents under paragraph (b)(i) and (ii) and prescribed documents that show proof of the relationship to the insured person;
- (d) may be made electronically.

(3) An insured person selecting a registered insurance administrator or any group or persons under an employer, union or other organizational entity shall pay the prescribed premiums to cover the levels of care and the associated benefits and benefit maximums.

(4) Where an insured person fails to select a registered health care provider or registered insurance administrator under section 76(2) (c)(i) for any reason —

- (a) a registered insurance administrator shall be assigned by the Authority; or
- (b) a registered health care provider may, with the written approval of the insured person, employer or employee or his or her legal guardian, facilitate the insured person's selection of that registered health care provider at the time of the visit by the insured person with the registered health care provider.

(5) The Authority shall set up rules of engagement subject to the approval of the Minister to determine the insured person that are

exempted from selecting a registered insurance administrator through the insurance exchange.

(8) Where a person is covered under group health coverage maintained by an employer, the selection of the registered insurance administrator must be in the prescribed manner.

Application for registration of a child

77.—(1) A parent or guardian of a child shall, within fourteen days of the birth of a child, make an application to the Authority for the registration of the child.

(2) An application under subsection (1) must be accompanied by a birth notification document.

(3) A parent or guardian who is making an application for registration of a child whose birth occurred outside Saint Lucia shall provide the Authority with a notification of birth or a birth certificate issued by the country in which the birth occurred.

(4) The Authority shall update the information of the child captured at birth on a continuous basis.

(5) A parent or guardian of a child shall within thirty days notify the Authority in writing of any change or error in the information captured at birth in relation to the child after the change in circumstances or on becoming aware of the error.

(6) A parent or guardian shall obtain a national insurance number for a child who is attending an educational institution from the time the child enters the educational institution.

(7) In this section, “child” includes a child who has one parent or both parents born in Saint Lucia.

Determination of application for registration under sections 76 and 77

78.—(1) Where the Authority receives an application for registration under sections 76 and 77, the Authority may grant approval or refuse to grant approval.

(2) Without limiting the generality of subsection (1), the Authority shall grant approval of an application for registration if the insured person has complied with the requirements under sections 76 and 77.

(3) Without limiting the generality of subsection (1), the Authority shall refuse to grant approval of an application for registration if the insured person —

- (a) has not complied with the requirements under section 76 or 77;
- (b) has submitted information or documents that are false or misleading;
- (c) a national identification document has expired, been suspended or revoked;
- (d) the person does not have a national insurance corporation number.

Registration and issue of health card

79.—(1) On the grant of approval of an application for registration under sections 76 and 77, an insured person or beneficiary shall be registered under the Plan and issued with a health card in the prescribed manner and form.

(2) A health card issued under subsection (1) must contain a unique identification number for each insured person or beneficiary.

(3) Within ninety days of a child attaining the age of eighteen years, the individual shall make an application in the prescribed form for updating of the registration details.

(4) On receipt of an application under subsection (3), the Authority shall verify and update the registration details of the individual and issue a new health card to the individual within thirty days of the application.

(5) The Authority shall, on the lapse of the ninety-day period, suspend the health card for an individual who has attained the age of eighteen years and have not updated the registration details.

Register of insured person or beneficiary

80.—(1) The Authority shall keep and maintain a register to be known as the Register of Insured Persons and Beneficiaries.

(2) On registration of an insured person or beneficiary, the Board shall enter the name of the insured person or beneficiary in the Register.

(3) The Authority shall record the following information in the register in relation to each insured person or beneficiary under this Act —

- (a) name and address;
- (b) telephone number and electronic mail address;
- (c) the date of registration;
- (d) other prescribed information that the Authority considers necessary.

(4) The Register under subsection (1) may be kept in electronic form.

(5) The Register must at all reasonable times be open to inspection by the public at the office of the Authority or by electronic means and a search may be effected and extracts of the Register may be obtained by the public on payment of the prescribed fee.

(6) The Authority may make alterations in the Register as are necessary.

Deregistration

81.—(1) The Authority shall deregister a person as an insured person or beneficiary —

- (a) on the death of the person;
- (b) if citizenship has been renounced under the Citizenship of Saint Lucia Act, Cap. 1.04;
- (c) information or document submitted is false or misleading.

(2) Where a death occurs, the Registrar of Civil Status appointed under the Civil Status Act, Cap. 4.02 shall notify the Authority of the death of the insured person or beneficiary and shall submit a copy of the certificate of death of the insured person or beneficiary to the Authority.

(3) Notwithstanding subsection (2), a household shall notify the Authority of the death of an insured person or beneficiary and shall submit a copy of the certificate of death of the insured person or beneficiary to the Authority.

(4) The Authority, on receipt of notification of the death of the insured person or beneficiary, shall revoke the health card of the deceased insured person or beneficiary.

(5) Where a deregistered person was making premium payments on behalf of the household, the other beneficiaries shall continue to access benefits until the end of the period for which the premiums have been paid.

Obligation of an employer

82.—(1) An employer may pay to a registered insurance administrator the premium of an employee consisting of the premium payable by the employer and the premium payable by the employee at a prescribed percentage.

(2) An employer that pays to a registered insurance administrator under subsection (1) shall pay the premiums to the registered insurance administrator at the end of each month.

(3) A manager of a pension scheme may pay to a registered insurance administrator the prescribed premium payable by a retiree.

(4) A self-employed or resident may pay to a registered insurance administrator the prescribed premium.

Re-selection of registered insurance administrator or registered health care provider

83.—(1) An insured person or beneficiary may in the prescribed manner, re-select once a year —

- (a) a registered insurance administrator;
- (b) a registered health care provider.

(2) Notwithstanding subsection (1), where —

- (a) a beneficiary —

- (i) has relocated to another constituency which makes it

no longer feasible for him or her to access a registered insurance administrator or registered health care provider,

- (ii) with good reason, is not satisfied with the health care services of a registered health care provider or the insurance business of a registered insurance administrator,
- (iii) is no longer employed by an employer that maintains group health coverage for its employees or otherwise is no longer eligible for such coverage; or
- (b) the services of a registered health care provider or registered insurance administrator are no longer available to an insured person or beneficiary,

the insured person or beneficiary may on application in writing and with the written approval of the Authority, re-select a registered insurance administrator or registered health care provider or both if necessary, in the prescribed manner.

Provision of updated information

84.—(1) An insured person or beneficiary shall provide to the Authority updated information in the case of —

- (a) an employment status change resulting from change of employment, termination of employment or retirement;
- (b) modification of the family membership resulting from the death of a member, birth of a child or arrival or departure of a family member;
- (c) modification of financial status;
- (d) geographic relocation;
- (e) any other change that impacts the insured person or beneficiary.

(2) An insured person or beneficiary shall provide an update under subsection (1) within a month after the change occurs.

(3) Notwithstanding subsection (2), updated information in case of death must be provided as soon as practicable but not later than four months after the death.

Travel insurance for health coverage

85.—(1) A non-resident visiting Saint Lucia for any purpose shall have travel insurance to receive health care services under a travel contract or policy.

(2) The travel contract or policy under subsection (1) must —

- (a) cover period of stay in Saint Lucia; and
- (b) provide for the following benefits —
 - (i) personal accident that may lead to death or permanent total disability,
 - (ii) emergency medical expenses,
 - (iii) emergency medical evacuation,
 - (iv) repatriation of mortal remains,
 - (v) hospital benefits,
 - (vi) prescription medicines, and
 - (vii) any other prescribed benefit.

(3) Notwithstanding subsection (2), the Authority shall not provide travel health insurance coverage for Saint Lucians or non-Saint Lucians.

**PART IV
BENEFITS**

Benefits

86. The benefits under this Act comprise —

- (a) Tier 1 benefits for universal essential coverage specified under Part 1 of the Schedule;
- (b) Tier 2 benefits for supplementary coverage specified under Part 2 of the Schedule;
- (c) Tier 3 benefits for catastrophic and overseas care specified under Part 3 of the Schedule.

Tariff for benefits, rates of premiums and payment mechanisms

87.—(1) The benefits must be based on a tariff.

(2) The Minister may, after consultation with the Authority, prescribe the tariffs applicable to the benefits and may prescribe rates of premiums for different benefits and prescribed payment mechanisms available to an insured person or beneficiary.

Receipt of benefit

88.—(1) An insured person or beneficiary may receive benefits and the benefits must be subject to the prescribed conditions and limitations including the presentation of the health card to access the benefit at a registered health care provider or registered insurance administrator.

(2) A beneficiary shall make such co-payments or be subject to such other cost-sharing obligations for benefits in the prescribed amounts and manner.

(3) Regulations made under this section shall provide the amount of any co-payments or other cost-sharing obligations to be paid by different categories of insured persons or beneficiaries.

(4) Nothing in this section precludes a person from procuring or maintaining private or additional health insurance coverage over and above what is covered under the first level of coverage provided through the Authority or the next levels provided by the insurance administrators through the health insurance exchange or from a risk-bearing entity whether independently or under an employer and the Authority may offer benefits to beneficiaries in return for a premium paid by the beneficiaries to the Authority and in this case the Authority is an insurance administrator.

(6) In this section, “health insurance exchange” means a regulated platform, digital or otherwise, under this Act or other enactment through which —

- (a) individuals and employees may compare, select and enrol in approved health coverage options; and
- (b) participating insurers or schemes offer standardized health benefit plans in accordance with specified rules in relation to pricing, eligibility and coverage requirements.

Coordination of coverage of benefits

89. Where an insured person or beneficiary is covered by private health insurance for a benefit, the private health insurance carrier shall be the primary payer of the prescribed benefits.

Suspension or termination of benefits

90.—(1) The Authority may suspend or terminate the benefits to an insured person or beneficiary.

(2) Without limiting the generality of subsection (1), the Authority may suspend or terminate the benefits to an insured person or beneficiary, if the insured person or beneficiary —

- (a) fails to pay the prescribed premiums;
- (b) commits fraud under the Plan;
- (c) fails to consent to disclose information; or
- (d) fails to comply with any other prescribed requirements.

(3) Suspension under this section does not negate the obligation of the insured person or beneficiary under this Act.

(4) Regulations made under this section must provide for the process to be carried out for the suspension or termination of the benefits.

PART V
CLAIMS AND PAYMENT OF BENEFITS

Claims

91.—(1) Subject to section 102, a registered health care provider may make to the Authority a claim for a benefit in the prescribed form or where there is no prescribed form, in such other manner as the Authority considers is sufficient in the circumstances of any particular case or class of cases if —

- (a) an insured person or beneficiary receives primary health care, secondary health care or tertiary health care from the registered health care provider;
- (b) the benefit that is applicable to the insured person or beneficiary is verified by the registered health care provider;

- (c) prior approval is received from the Authority for high-cost procedures, specialist services, diagnostic services, medicines or overseas care;
- (d) an insured person is referred to another health care provider or level of care.

(2) Where a registered health care provider makes a claim for a benefit on a prescribed form other than the form appropriate to the benefit claimed, the claim may, if it contains sufficient particulars, be treated as if it had been made on the appropriate form.

(3) Notwithstanding subsection (2) where a registered health care provider makes a claim for a benefit on a prescribed form other than the appropriate form, the Authority may require, subject to section 102, a registered health care provider to complete the appropriate form.

Information to be given

92.—(1) Subject to section 102, a registered health care provider that makes a claim for a benefit under section 91 shall furnish —

- (a) date and place that an insured person or beneficiary received the primary health care, secondary health care or tertiary health care;
- (b) evidence of approval from the Authority or referral to another health care provider, if required;
- (c) information on the insured person or beneficiary including —
 - (i) the identity, date of birth, usual place of residence and occupation of the insured person or beneficiary,
 - (ii) the position in regard to any benefit under this Act, available sources of income and the amounts contributed by any person towards the maintenance of the insured person or beneficiary, and
 - (iii) in the case of a claim in respect of or based on a relationship to an insured person of a wife, husband, widow or a widower —

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- (A) a certificate of the marriage; or
- (B) proof of registration as beneficiary; and
- (C) a declaration signed by the wife, husband, widow or a widower that the information is true to the best of his or her knowledge and belief;
- (d) in the case of a claim for a benefit in respect of a child, a certificate relating to the birth of the child and such other information as the Authority requires;
- (e) a bill that complies with the tariff and payment mechanisms under section 87;
- (f) other certificates, documents, information and evidence as the Authority requires for the purpose of determining the claim.

(2) The Authority may accept in support of a claim for a benefit and in the absence of the certificate or documents under subsection (1) —

- (a) as proof of kinship or marriage, evidence of a third person or other documentary evidence;
- (b) as proof of age, extracts from baptismal records or school records or other evidence as the Authority considers satisfactory.

Date of claim

93. The date of a claim for a benefit made under section 91 is the date of receipt of the claim by the Authority.

Defective or incomplete claim

94.—(1) If a claim is defective or incomplete at the date of receipt by the Authority, the Authority may refer the claim to the registered health care provider and if the form is returned properly completed within one month from the date on which the claim is referred, or other period as the Authority specifies, the claim may be treated as if the claim had been properly made in the first instance.

(2) A registered health care provider may amend a defective or incomplete claim for a benefit before a decision is given by the Authority, and a defective or incomplete claim for a benefit that is amended is treated as if the claim for the benefit is properly made in the first instance.

(3) Where it appears to the Authority that a registered health care provider that made a claim for a benefit is entitled to some other benefit, the claim may be treated by the Authority as a claim in the alternative for that other benefit.

Time for claiming benefits

95.—(1) The time for claiming benefits is not later than three months from the date on which the expenses were incurred by a registered health care provider.

(2) A failure to submit a claim for a benefit within the time limit under subsection (1) results in the loss of the benefit unless it is shown by the registered health care provider to the satisfaction of the Chief Executive Officer that there is good cause for delay in submitting the claim, in which case, the registered health care provider is disqualified from receiving the benefit if the claim had been made on the earlier date.

Determination of claim

96.—(1) On receipt of a claim, the Board shall make a determination to —

- (a) approve a claim;
- (b) reject a claim.

(2) In making a determination under subsection (1), the Authority shall —

- (a) verify beneficiary eligibility, the status of the registered health care provider, benefit coverage, prior authorization or referral requirements, tariffs, duplicate claims, benefit limitations, coordination with other payers and indicators of fraud, waste or abuse;
- (b) make such inquiries as the Authority considers appropriate.

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(3) Without limiting the generality of subsection (1)(b), the Authority may reject a claim if the claim is incomplete or technically invalid.

(4) After making a determination under this section the Authority shall give notice to the registered health care provider.

(5) A notice under subsection (4) must —

- (a) be in electronic form;
- (b) be in the prescribed form;
- (c) state the —
 - (i) primary health care, secondary health care or tertiary health care claimed,
 - (ii) amount billed,
 - (iii) amount allowed,
 - (iv) amount payable, and
 - (v) amount adjusted or denied;
- (d) contain the reasons for the determination including the prescribed payment methodology;
- (e) be accompanied by a remittance advice in the prescribed form and manner.

Time and manner of payment of benefit

97.—(1) A payment of a benefit must not be made for expenses at a registered health care provider for a period of more than twelve months after the date on which the claim for the benefit is made.

(2) Where a claim is approved under section 96, a benefit must be paid by the Authority in the prescribed form and manner —

- (a) in the case of a Tier 1 benefit, to a registered health care provider;
- (b) in the case of a Tier 2 benefit, to a registered health care provider through reimbursement from a registered insurance administrator or recovery of the amount from an uninsured patient;

- (c) in the case of a Tier 3 benefit, to a registered health care provider or overseas health care provider.

(3) The Authority may enter into a cost sharing agreement or may require the benefit to be paid in full or partially paid through subrogation if the benefit is payable —

- (a) under the National Insurance Corporation Act, Cap. 16.01;
- (b) to an insurance company other than a registered insurance administrator; or
- (c) to a third party under the law.

Benefit not payable if payment is not obtained within the specified time

98.—(1) A benefit is not payable if payment of the sum for the primary health care, secondary health care or tertiary health care provided by the registered health care provider is not obtained within the period of six months or such longer period as the Chief Executive Officer determines in the circumstances of any particular case, after the date on which the sum becomes payable.

(2) In calculating the period of six months under subsection (1), account must not be taken of —

- (a) any period during which a cheque or bank draft containing the sum is in the possession of the Authority, post office or financial institution at which the sum is payable other than a period after written notice is given that the cheque or, bank draft is available for collection;
- (b) any period during which the Authority has, after consideration, represented that a cheque or bank draft containing the sum has not been received, or has been lost, mislaid or stolen;
- (c) any period during which determination of any question as to such extinguishment is pending.

Information to be given when obtaining payment of benefit

99. A registered health care provider shall furnish in the manner and at the times the Authority determines, certificates and other

documents and information or facts affecting the benefit or to receipt as may be required as a condition on which any sum is receivable or otherwise by the Authority.

Suspension or forfeiture of payment of benefit

100.—(1) Where a registered health care provider that makes a claim for a benefit under this Act willfully obstructs, or is guilty of misconduct in connection with an examination or treatment that is required under this Act or in connection with any proceedings under this Act for the determination of a benefit, the registered health care provider shall, subject to this section, forfeit the benefit claimed, for such period as the Authority determines.

(2) Proceedings on a claim or payment of a benefit may be suspended for such period as the Authority determines.

(3) Nothing in this section providing for the forfeiture of a benefit for failure to comply with this Act or obstruction or misconduct in connection with a medical examination or treatment, authorizes the disentitlement of a registered health care provider to benefit for a period of more than six weeks on any forfeiture.

Obligations of registered health care provider to notify of change of circumstances

101.—(1) A registered health care provider in receipt of a benefit shall inform the Authority within one week of the occurrence of a change in circumstances affecting the receipt of the benefit by the registered health care provider or the rate at which the benefit is payable.

(2) The Authority may require a registered health care provider that has received a benefit to furnish documentary evidence in the prescribed manner that the registered health care provider is and the conditions governing the benefit continue to be fulfilled and if such evidence is not given to the Authority within the time required, the Authority may suspend payment of the benefit until the date on which the evidence is given.

PART VI
DIGITALIZATION AND UNIVERSAL HEALTH COVERAGE
DATA GOVERNANCE

Digitalization

102.—(1) The Authority shall digitalize all processes and services under this Act using reliable, secure, inter-operable, verifiable and responsive technology through an information system.

(2) Processes and s ervices under subsection (1) include —

- (a) registration;
- (b) identification;
- (c) contributions;
- (d) public-private partnerships;
- (e) claims management;
- (f) settlement of claims; and
- (g) electronic funds transfer and other digital payment methods.

(3) The digitalization of processes and services under this Act shall comply with the Data Protection Act, Cap. 8.18.

Classification of universal health coverage data

103. For the purposes of this Act, health data is classified into the following categories —

- (a) data on the Register;
- (b) data on public-private partnerships;
- (c) data on contributions;
- (d) data on premiums and payment of premiums; and
- (e) data on claims and settlement of claims.

Governing principles

104. Universal health coverage data is governed by the following principles —

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- (a) improvement of client health, safeguard of individuals and communities against harm and violations;
- (b) data security throughout the entire data life-cycle;
- (c) equity and accountability;
- (d) privacy and confidentiality; and
- (e) accuracy and reliability.

Establishment of universal health coverage data governance framework

105.—(1) The Authority shall, in consultation with the Ministry responsible for health, establish a universal health coverage data governance framework.

(2) Without limiting the generality of subsection (1) the Authority shall —

- (a) develop guidelines to promote effective use of universal health coverage data including data migration;
- (b) establish standards for integration, interoperability and exchange of health data;
- (c) regularly update and make the universal health coverage data dictionary available for utilization within the system;
- (d) establish standards for and conduct routine data quality checks in the system;
- (e) provide for the security and accountability of data for the system while promoting appropriate data use and sharing;
- (f) provide guidance on the integration and interoperability of universal health coverage information systems into the system in accordance with specified standards; and
- (g) require registered insurance administrators and registered health care providers to report universal health coverage data in accordance with the prescribed formats and platforms.

Universal health coverage data custodian

106. The Authority shall be the custodian for all universal health coverage data in Saint Lucia.

Universal health coverage data use

107.—(1) The Authority shall use universal health coverage data for the public good.

(2) The Authority shall provide universal health coverage data to the Minister for action.

PART VII
UNIVERSAL HEALTH COVERAGE FUND

Actuarial projection and review of the Fund

108.—(1) The Board, shall with the assistance of an actuary approved by the Minister, review the operations of this Act at the end of every fifth year, and in such review, make a report to the Minister on the financial condition of the Fund and the adequacy or otherwise of the contributions payable under this Act to support the benefits payable, having regard to other liabilities under this Act.

(2) The Minister shall, as soon as possible after receiving a report under subsection (1), lay a copy of the report before the House of Assembly.

Accounts and audit of the Fund

109.—(1) The Board shall within three months after the end of each financial year have the accounts of the Fund audited by an independent auditor appointed by the Board, who shall conduct the audit in accordance with generally accepted international auditing standards and provide the Board with an audited financial statement and a report on the financial statement.

(2) A member of the Board or staff of the Authority shall grant to the auditor appointed under subsection (1), access to books, deeds, contracts, accounts, vouchers, or other documents which the auditor considers necessary.

(3) An auditor may require a member of the Board or staff of the Authority to appear, make a signed statement or provide information in relation to the books, deeds, contracts, accounts, vouchers, or other documents as the auditor considers necessary.

(4) Where a member of the Board or staff of the Authority contravenes subsection (3) —

- (a) in the case of a member of the Board, his or her appointment may be revoked under section 18;
- (b) in the case of the staff of the Authority his or her appointment may be terminated.

Quarterly report of the Fund

110.—(1) The Board shall no later than thirty days after the end of each quarter submit to the Minister a quarterly report on the Fund during the preceding quarter.

(2) A quarterly report under subsection (1) must include a report of the inflows and outflows of the Fund, the performance of the Fund during the quarter and the value of the assets and where the assets are held at the end of each quarter.

Annual report on the Fund

111.—(1) The Board shall no later than sixty days after the end of each financial year submit to the Minister an annual report on the Fund during the preceding financial year.

(2) An annual report under subsection (1) must include —

- (a) a balance sheet of the Fund;
- (b) investments of the Fund;
- (c) all payments into the Fund;
- (d) the total income received from investments of the Fund;
- (e) all the payments from the Fund.

(3) The Minister shall lay before Parliament reports submitted to him or her by the Board under subsection (1) no later than fifteen days after the report is received or within fifteen days of the first

sitting of Parliament after the Minister receives the reports, whichever is applicable.

PART VIII

UNIVERSAL HEALTH COVERAGE TRIBUNAL

Establishment of Universal Health Coverage Tribunal

112. There is established a Tribunal to be known as the Universal Health Coverage Tribunal.

Constitution of Tribunal

113.—(1) The Tribunal comprises five persons appointed by the Minister —

- (a) an attorney-at-law with at least ten years of experience nominated by the Bar Association;
- (b) four persons having experience in —
 - (i) insurance business,
 - (ii) health care services, or
 - (iii) consumer protection.

(2) The Minister shall appoint the attorney-at-law as the Chairperson of the Tribunal.

(3) The Tribunal is appointed for a period of three years.

(4) A member of the Tribunal is eligible for reappointment.

Functions of the Tribunal

114. The functions of the Tribunal are to resolve —

- (a) complaints made to the Tribunal by the Board;
- (b) disputes between the Board and a registered insurance administrator, registered health care provider, insured person or beneficiary.

Powers of the Tribunal

115.—(1) The Tribunal has the power to —

- (a) summon a person to attend and give evidence or to produce a document at a hearing of the Tribunal;
- (b) make an order under section 123.

(2) A person summoned under subsection (1)(a) has, in respect of his or her attendance, the giving of evidence, the disclosure of any communication or the production of any document, the same rights and privileges as a person summoned before a court of law.

(3) A person shall not —

- (a) without sufficient cause, fail or refuse to obey a summons issued by the Tribunal;
- (b) being a witness at a hearing of the Tribunal, without sufficient cause —
 - (i) leave a hearing without the permission of the Tribunal, or
 - (ii) refuse to answer a question put to him or her by or with the permission of the Tribunal; or
- (c) without sufficient cause, obstruct or interrupt a hearing of the Tribunal.

(4) A person who contravenes subsection (3) commits an offence and is liable on summary conviction to a fine not exceeding three thousand dollars or to imprisonment for a term not exceeding one year or to both.

(5) In all legal proceedings, a document produced under subsection (1)(a) must be received as *prima facie* evidence of the truth of the statements contained in the document.

Resignation from the Tribunal

116.—(1) A member of the Tribunal, may resign from office by giving written notice to the Minister through the Chairperson, and the resignation takes effect as from the date specified in the notice and if a date is not specified, the date of receipt of that notice by the Minister.

(2) The Chairperson may resign from his or her office, by giving written notice to the Minister, and such resignation takes effect as from the date specified in the notice and if a date is not specified, the date of receipt of that notice by the Minister.

Revocation of appointment on Tribunal

117.—(1) The Minister may revoke the appointment of a member of the Tribunal, including the Chairperson, if the member or Chairperson

—

- (a) neglects his or her duty as a member;
- (b) engages in misconduct; or
- (c) is absent from three consecutive meetings without an excuse.

(2) Where the Minister revokes the appointment of a member of the Tribunal or the Chairperson, the Minister shall state the reasons for the revocation.

Appointment of temporary members

118.—(1) The Minister may appoint another person to act temporarily in place of the Chairperson or a member where the Chairperson or a member of the Tribunal —

- (a) is unable to perform the functions of the office of Chairperson or member of the Tribunal;
- (b) is absent;
- (c) dies;
- (d) resigns under section 116; or
- (e) is no longer a member as a result of his or her appointment being revoked under section 117.

(2) A person appointed under subsection (1) shall be appointed in a manner that complies with section 113 for the constitution of the Tribunal and holds office —

- (a) in the case of the absence or inability of the Chairperson or member to perform his or her functions, for the portion of the term of the absence or inability;

- (b) in the case of the death, resignation or revocation of appointment of the Chairperson or member, the unexpired portion of the term of the former member.

Publication

119. The appointment of a member of the Tribunal and any change in the constitution of the Tribunal, whether by death, resignation, removal or otherwise, shall be published in the *Gazette*.

Recording Secretary

120.—(1) The Tribunal shall appoint a Recording Secretary of the Tribunal who has no voting rights.

(2) The Recording Secretary shall keep a written record of all proceedings of the Tribunal, which shall be confirmed by the Chairperson.

Remuneration and allowances

121. A member of the Tribunal must be paid remuneration and allowances as Cabinet determines.

Hearings of the Tribunal

122.—(1) Subject to subsection (2) and section 113, a hearing of the Tribunal shall be conducted by the Tribunal.

(2) Where a member of the Tribunal, other than the Chairperson, is unable to conduct hearings to completion, the Chairperson and the other member shall continue the hearings from the stage at which it was last heard by the previous member and conclude the hearing.

(3) The Tribunal may convene a hearing within thirty days of receipt of a complaint under section 124.

(4) The Tribunal shall convene a hearing under subsection (3) at a time, place and on a day as may be necessary or expedient for the discharge of its functions.

(5) The quorum for hearings of the Tribunal is three including the attorney-at-law.

(6) At least fourteen days before the date fixed for a hearing, the Tribunal shall by notice in writing advise the Board, registered insurance administrator, registered health care provider, insured person or beneficiary of the date, time and place for the hearing.

(7) A notice under subsection (6) must be sent to the Board, registered insurance administrator, registered health care provider, insured person or beneficiary personally to his or her given address for service or by sending the notice by registered mail.

(8) At least seven days before the hearing, the Tribunal, shall, whenever practicable, cause the notice under subsection (6) to be published in the *Gazette*.

(9) Where the person making a complaint does not attend the hearing, having had due notice of the time and place of hearing, the Tribunal may dismiss the complaint, unless having received a reasonable excuse for the non-appearance of the person who made the complaint the Tribunal thinks it fit to adjourn the hearing.

(10) Where a person —

- (a) refuses or neglects without reasonable cause, to attend a hearing in compliance with the requirements of a notice under subsection (6); or
- (b) departs from a hearing without the authority of the person holding the hearing, the Tribunal may proceed with the hearing and make a decision in his or her absence in accordance with the provisions of this Act.

(11) At a hearing of the Tribunal a person may appear in person or by a representative.

(12) A hearing by the Tribunal must be in private.

(13) A member of the Tribunal shall, as soon as is practicable inform the Chairperson of a matter in which he or she has, directly or indirectly, personally or by his or her relative, partner, business associate or company, any pecuniary or business interest and that member shall not take part, directly or indirectly, in any hearing by the Tribunal on that matter.

(14) The validity of a hearing of the Tribunal is not affected by a vacancy in its membership or by a defect in the appointment of a member.

(15) At the hearing each party may adduce evidence and call witnesses.

Orders of the Tribunal

123.—(1) The Tribunal may make an order —

- (a) to require the Board to —
 - (i) suspend or revoke a certificate,
 - (ii) impose on the registered insurance administrator or registered health care provider a condition specified in the certificate,
 - (iii) require the registered insurance administrator or registered health care provider to take or refrain from taking a specified action,
 - (iv) require the registered insurance administrator or registered health care provider to be subject to periodic supervision or inspection as determined by the Board,
 - (v) caution or reprimand the registered insurance administrator or registered health care provider;
- (b) to adjourn the hearing and fix the time and place at which the hearing is to be resumed after adequate notice is given;
- (c) to dismiss the complaint without calling a defence if the evidence adduced is insufficient.

(2) An order of the Tribunal must be —

- (a) by a majority of votes of those members present and voting and, in addition to an original vote, the Chairperson has a second or casting vote in any case in which the voting is equal;
- (b) authenticated by the signature of the Chairperson;

- (c) sent to the Board, registered insurance administrator, registered health care provider, insured person or beneficiary in writing.

(3) Where the Tribunal makes an order under subsection (2), the Tribunal shall keep a record of its decision.

Making a complaint

124.—(1) A person who is aggrieved by the decision of the Board, regulated insurance administrator or regulated health care provider, may complain to the Tribunal.

(2) The Tribunal may lodge a complaint received under subsection (1).

(3) A complaint under this section must —

- (a) be made in writing;
- (b) contain particulars of the matter complained of;
- (c) identify the person against whom the complaint is being made;
- (d) identify the complainant;
- (e) contain a statement that the complainant consents to a copy of the complaint or particulars of the complaint being given to the Board, registered insurance administrator, registered health care provider, insured person or beneficiary; and
- (f) be lodged with the Tribunal and the Board.

(4) The Tribunal shall give a person who makes a complaint reasonable assistance to enable the person to make the complaint under this section.

(5) A person shall not make or produce a false or misleading statement, orally or in writing, in connection with a complaint.

(6) A person who contravenes subsection (5) commits an offence and is liable on summary conviction to a fine not exceeding ten thousand dollars or to imprisonment for a term not exceeding two years.

Procedure

125.—(1) On receiving a complaint, the Tribunal shall —

- (a) record the date on which the complaint was received and acknowledge receipt; and
- (b) within thirty days of receipt of the complaint, determine whether to accept or reject the complaint.

(2) The Tribunal may require a complainant to provide further particulars of a complaint.

(3) The rules of procedural fairness must be observed in determining a complaint under this Part.

(4) The Tribunal shall reject a complaint if the Tribunal considers that —

- (a) the complaint is without foundation or frivolous or vexatious;
- (b) the matter complained of is not substantial.

Appeals

126. A registered insurance administrator, registered health care provider, an insured person, beneficiary or the Board may appeal to the High Court against a decision of the Tribunal.

PART X
MISCELLANEOUS

Cooperation and information sharing

127.—(1) The Authority may cooperate with a government agency, by sharing 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 considers that such cooperation or information may be relevant to the requesting agency and 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 functions.

(2) Notwithstanding subsection (1), the Authority shall not share any information that relates to the medical history or medical status of an individual.

(3) Subsection (2) does not apply to a disclosure of information —

- (a) lawfully required or permitted by any court of competent jurisdiction within Saint Lucia;
- (b) in respect of the affairs of a beneficiary where the consent of the beneficiary or guardian has been given voluntarily;
- (c) where the information disclosed is in a manner that does not enable the identity of an insured person, beneficiary, registered insurance administrator or registered health care provider to which the information relates to be ascertained.

(4) Any information shared under this section must be shared securely and in accordance with this Act.

(5) For the purposes of this section, the Authority may enter into an appropriate information sharing agreement.

Power to require information

128.—(1) In the performance of its functions, the Authority may at all reasonable times require —

- (a) a registered insurance administrator or a registered health care provider to supply such information as the Authority may reasonably require or to produce for examination such records that are required to be kept under this Act;
- (b) an insured person or beneficiary to supply such information as the Authority may reasonably require for the purpose of enabling the Authority to supply such information to perform its functions under this Act;
- (c) an employer to supply such information as the Authority may reasonably require for the purpose of enabling the Authority to perform its functions under this Act;

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- (d) a person involved in the regulation of insurance businesses or health practitioners to supply such information as the Authority may reasonably require to perform its functions under this Act.

(2) Where —

- (a) a registered insurance administrator or a registered health care provider fails or refuses to produce a record or supply information as is required under subsection (1), the registered insurance administrator or registered health care provider commits an offence and is liable on summary conviction to a fine not exceeding two hundred and fifty thousand dollars and may in addition be subject to termination from the Plan;
- (b) an insured person, a beneficiary or an employer who fails or refuses to produce a record or to supply information under subsection (1) is liable to pay the full cost of any medical service provided to the insured person or beneficiary that is otherwise paid under the Plan.

Confidentiality

129.—(1) A person who works with or comes into contact with data or information relating to —

- (a) the affairs of the Authority;
- (b) the affairs of a beneficiary; or
- (c) the affairs of an insurance administrator or a health care provider,

received in relation to any functions performed in accordance with this Act, shall —

- (i) regard and deal with as secret and confidential such data or information,
- (ii) not disclose such data or information without the proper authorization, and
- (iii) take appropriate security measures to prevent unauthorized access to, or alteration disclosure or

destruction of such data and against accidental loss or destruction.

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

- (a) lawfully required or permitted by a court of competent jurisdiction within Saint Lucia;
- (b) for the purposes of assisting the Authority to exercise any function conferred on it by this Act, by any other Act, or by Regulations made under this Act;
- (c) in respect of the affairs of a beneficiary where the consent of the beneficiary or legal guardian, has been voluntarily given;
- (d) where the information disclosed is or has been available to the public from a lawful source;
- (e) where the information disclosed pertains to one's self; or
- (f) where the information is disclosed in a manner that does not enable the identity of any beneficiary, insurance administrator or health care provider to which the information relates to be ascertained.

(3) A person who contravenes this section commits an offence and is liable on conviction to a fine not exceeding fifty thousand dollars or to a term of imprisonment not exceeding ten years, or to both fine and imprisonment.

Review of this Act

130.—(1) This Act shall be reviewed by a committee of Parliament appointed by the Prime Minister in consultation with the Leader of the Opposition for that purpose.

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

Amendment of Schedule

131. The Minister may, after consultation with the Authority, amend the Schedule.

Regulations

132.—(1) The Minister may, on the recommendation of the Authority, make Regulations for the better carrying out of the provisions and purposes of this Act.

(2) Without limiting the generality of subsection (1), the Minister may make Regulations —

- (a) prescribing the categories of beneficiaries and the applicable benefits relating to the categories of beneficiaries;
- (b) prescribing the procedure, rate and mode for the payment of contributions by beneficiaries and employers;
- (c) prescribing matters related to information sharing, maintenance of records, privacy and data protection;
- (d) prescribing the registration criteria for an insurance business participating in the Plan;
- (e) prescribing the registration criteria for a health care provider participating in the Plan;
- (f) prescribing the categories of persons and the means of identifying the categories of persons, who may be exempted from paying contributions, co-payments or other cost sharing obligations under the Plan;
- (g) prescribing matters relating to the setting of payments for registered health care providers, registered insurance administrators and the risk adjustment mechanism for registered health care providers and registered insurance administrators;
- (h) prescribing procedures for the resolution and determination of grievances;
- (i) prescribing the percentage of the Fund to be used for activities that directly facilitate access to primary health care, secondary health care or tertiary health care;
- (j) prescribing the appointment, functions and procedure of committees;

- (k) prescribing the manner and form of any forms to be used under this Act;
- (l) requiring the reporting of data by a registered health care provider, and the form and manner of the reports;
- (m) requiring the reporting of data by a registered insurance administrator and the form and manner of the report of data;
- (n) prescribing any other matter for the better carrying out of the purposes of this Act.

(3) A committee appointed under this Act shall be consulted by the Authority as appropriate prior to the making of any recommendation to the Minister for the making of Regulations made under subsection (2).

(4) Regulations made under this section may notwithstanding section 17(10) of the Interpretation Act, Cap. 1.06 provide for the imposition of a fine not exceeding fifty thousand dollars for any contravention or failure to comply with the provisions of the Regulations.

SCHEDULE

(Sections 71, 72, 73,86 and 96)

PART 1

TIER 1 - BENEFITS FOR UNIVERSAL ESSENTIAL COVERAGE

All health care services delivered by a registered health care provider up to the limit specified under section 71.

PART 2

TIER 2 - BENEFITS FOR SUPPLEMENTARY COVERAGE

1. Specialist outpatient care
2. Diagnostics
3. Elective procedures
4. Higher-level services

PART 3

TIER 3 - BENEFITS FOR CATASTROPHIC AND OVERSEAS CARE

1. High-cost conditions after Tier 1 and 2 maximum contributions are met.
2. High-cost conditions including —
 - (a) cancer;
 - (b) dialysis;
 - (c) stroke;
 - (d) cardiac care.
3. Overseas referrals

Passed in the House of Assembly this day of , 2026.

.....
Speaker of the House of Assembly.

No.]

Universal Health Coverage Act

Passed in the Senate this day of , 2026.

.....
President of the Senate.