



**Ministerial Statement to the
House of Assembly
by the Minister of Health, Seniors and Environment
The Honourable Jeanne Atherden, JP, MP
On 22nd May, 2015**

STANDARD HEALTH BENEFIT

Mr. Speaker, during this Session, I will be introducing amendments to set the Standard Premium Rate. This year I am pleased to also bring to this **Honourable House** important changes that are being made to Bermuda's minimum health insurance package: **the Standard Hospital Benefit**.

I have already advised at this Honourable House about the Bermuda Health Strategy Plan, and I would like to stress that the changes being introduced at this time are very much to support the strategic reforms planned for the health system.

The **Health Insurance Act 1970** contains the foundation of our current national health insurance system, and there are a number of regulations associated with the Act, some of which are updated annually and others periodically. In particular, the Health Insurance (Standard Hospital Benefit) Regulations define the minimum, mandated package of health insurance and require this Honourable House to set its price.

The **Standard Hospital Benefit (or SHB)** as defined by the '**Standard Hospital Benefit Regulations 1971**' is the minimum, mandated package of health insurance. Employers must provide at least this level of cover for their employees and their non-employed spouses, and insurers have to include this package in their policies at the regulated price or the **Standard Premium Rate**.

The Government subsidizes children, the indigent and seniors at prescribed rates, set by the Health Insurance Act 1970.

Currently **Mr. Speaker**, SHB covers a majority of local inpatient and outpatient hospital services, some diagnostic imaging procedures outside of the hospital, and select home medical services. The premium for this minimum package of benefits, the Standard Premium Rate (SPR), is comprised of a Standard Hospital Benefit (SHB) component and a Mutual Reinsurance Fund (MRF) component.

The SPR is actuarially priced annually, and set in law by this Honourable House. However, because Government pays for the subsidized populations, part of the cost of SHB coverage is borne by the Consolidated Fund.

Mr. Speaker, annually, the Bermuda Health Council presents to the Ministry of Health, Seniors and Environment the actuarial review of the SHB and MRF prepared by consultant actuaries to recommend the SPR for the upcoming fiscal year. The SPR is calculated on the basis of all insurers' SHB claims experience, projected changes in fees and utilization, and any benefit changes.

Mr. Speaker, in 2014 the Health Council undertook a review of the coverage under SHB and recommended benefit changes to promote more appropriate use of healthcare resources. These were priced by the Council's actuaries and represent the first efforts to move from a hospital-based SHB to a more cost-efficient minimum benefit.

On consideration of the various scenarios presented, the following changes are brought about by the **Health Insurance (Miscellaneous) Amendment Act 2015** which I will table today. There are three types of changes that together result in a net increase to the SPR of 12%. The breakdown of these changes is as follows:

First, new standard benefits will be introduced to protect under-insured patients and promote cost-efficiency. Overall these will reduce the SPR by \$1.07. The benefits are:

- a. **Artificial limbs** cover will be increased from the current lifetime maximum of \$15,000 to \$30,000. This cover has not been adjusted in over a decade and has not kept pace with technological advances and real-cost changes. The new limit will assist patients on the lowest insurance plans.
- b. **Hospital-based professional fees** will be included under SHB. This refers to the BHB fee schedules 38 (professional fees) and 48 (facility fees). These are currently excluded from SHB for historical reasons, but have recently caused hardship for persons on the lowest insurance plans who were unexpectedly billed for the services. Comprehensive plans cover the schedules either as supplemental benefits or misreport them as SHB. Adding these fees to SHB will eliminate under-insured patients from being billed for services that are a necessary part of their hospital-based treatment.
- c. **Post-acute care in community settings** will be covered as SHB for select, eligible, non-acute patients. This seeks to move eligible patients from \$30,000 a month beds to \$5,000 to \$10,000 a month beds (approx.). The benefit is currently priced based on the projected availability of fifteen community beds and reduces the premium due to the lower costs.
- d. **Emergency ambulance services have been expanded** to provide additional, necessary coverage across the Island; and, lastly.
- e. **Screening mammograms will be covered as SHB when they are in adherence with specific Clinical Guidelines.** Mammography represents 30% of all diagnostic imaging costs in Bermuda. Currently, the health system follows the American College of Radiology guidelines for mammography which recommend annual screenings for all women aged over 40 years. A clinical review has proposed changing the Bermuda standard to follow the United States Preventive Services Task Force (USPSTF) Guidelines, which recommend biennial screening for healthy, asymptomatic women aged 50 to 74 years.

Women with a family history or other risk factors will still be covered for testing with a physician referral. This will result in better use of scarce healthcare resources, while following best-practice international guidelines on screening. Accordingly, SHB coverage for screening mammograms will be required to adhere to the USPSTF guidelines.

These benefit changes will serve to better protect under-insured populations, without a significant cost to the standard premium.

The second set of changes pertain to the allowance for fees and utilization. These have been kept to a minimum, and they add only \$2.73 to the SPR:

- a. **BHB fees will be increased by 1%** to offset service delivery cost increases (e.g. medical supplies); and
- b. **the allowance for changes in utilization has been held at zero per cent**, based on the most recent claims experience of the subsidy plans, the various benefit revisions and BHB modernization proposals that are anticipated to prevent uncontrolled escalation of utilization.

Mr. Speaker, the third set of changes pertains to the **Mutual Reinsurance Fund (MRF)**. These represent the largest increase to the SPR, amounting to \$63.74.

The MRF has acted as an experimental fund to cover new benefits that are subsequently downloaded to the SHB. It has also acted as a transfer mechanism to help fund the Government's low-cost insurance products for the benefit of the general public. Last year a \$0.67 cent transfer was introduced to assist in funding the Bermuda Health Council.

The MRF is funded by a premium which is included in each health insurance contract, and is transferred by insurance carriers to a collective fund administered by the Health Insurance Department.

Mr. Speaker, this year, the MRF has been structured to fund a pilot health service akin to the medical clinic, to provide necessary additional funding for BHB's new acute care wing, and to absorb a greater proportion of the risk associated with low-cost plans for high-risk populations. They are broken down as follows:

- a. **Non-Communicable Disease Primary Care Pilot:** A pilot programme will provide primary care for eligible uninsured, indigent persons and HIP policy holders who are Financial Assistance (FA) clients, when such persons have a pre-defined chronic, non-communicable disease (NCO), namely: diabetes, hypertension, heart disease, asthma and obesity. Eligible persons will receive primary care, case management and prescription drugs to control NCDs in order to avoid costly Emergency Department visits and unnecessary hospitalizations. The projected cost of \$6.19 on the SPR. This pilot benefit is in development, and we expect to see it implemented later in 2015.
- b. **BHB Transfer:** With the opening of the new acute care wing, and a crisis of funding due to historical challenges, the Island's hospitals require additional funding to support their proactive sustainability plan. In order to avoid continued increases in fees, which could add more than \$8 million to the subsidy costs, a direct transfer to BHB will be introduced to help fund its operations. To raise an estimated \$13.7 million, the new transfer will increase the SPR by \$23.64. This prevents BHB's fees from becoming less competitive compared to local and overseas providers, protects the subsidy budget, and provides secure funding for BHB.
- c. **HIP Transfer:** The HIP claims experience is severely compromised by the risk it absorbs as the insurer of last resort and the health needs of the HIPFA clients. Annual capital injections to support the plan help to keep the HIP premium affordable for the working poor, but such capital will be reduced in the upcoming fiscal year. In anticipation of this, the MRF transfer to HIP will be increased from \$14.00 to \$18.40 per month. This has an impact on the SPR of \$4.40.
- d. **Health Council Transfer:** Currently the Council receives \$0.67 cents monthly per insured person via the MRF. To help fund operations and reduce the burden on the consolidated fund, offset a reduction in their grant, and in anticipation of

additional resource needs to regulate healthcare providers, the transfer will be increased to \$1.00. This has an impact on the SPR of \$0.33 cents.

Mr. Speaker, These changes will help us direct healthcare to more appropriate, cost-effective settings, and protect the subsidy budgets.

Mr. Speaker, Honourable Members will recall that the relatively new **Home Medical Services (HMS)** benefit under SHB is covered by all insurers. Evaluation of the pilot phase of the programme found it to have saved an estimated \$100,000 for the health system by delivering select services outside the acute-care setting. The benefit is not currently covered by subsidy. Given its proven cost-effectiveness, the indigent subsidy will now cover HMS to help reduce cost to the subsidy budget.

Lastly, and most importantly, **Mr. Speaker,** the Standard Hospital Benefit will be re-named the "**Standard Health Benefit**". This will reflect the changes being rolled out to promote more efficient use of healthcare resources, greater reliance on less costly, non-acute care settings, and increased emphasis on secondary prevention and disease management.

Mr. Speaker, this Government is committed to working hard to ensure that wider health system improvements take place so funds are dedicated to protecting the most vulnerable. We aim to achieve this task with the assistance of many partners in the private and public sectors, and the changes introduced this year will help to ensure we use healthcare resources more efficiently and improve healthcare coverage and access.

Thank you, **Mr. Speaker.**