OVERVIEW OF 2019 SPR, BHB FUNDING & HEALTH FINANCING REFORM

May 2019

The Hon. Kim N. Wilson, JP, MP
Minister of Health

GOVERNMENT OF BERMUDA
Ministry of Health

Overview

- Context: Bermuda's health situation
- Standard Premium Rate status
- BHB funding change
- Health financing reform
- Bermuda Health Strategy update

THE CONTEXT

Bermuda's health situation

We have some strengths and some challenges

Strengths

MATERNAL AND CHILD HEALTH

0 maternal deaths, and low infant mortality

COMMUNICABLE DISEASE CONTROL

Good outbreak control

LIFE EXPECTANCY

On par with high-income countries

HEALTHCARE ACCESS

98% of adults get regular health checks

Challenges

Overweight and Obesity

75% adults are overweight or obese

LONG TERM CARE

Ageing population and limited care options

CHRONIC NON-COMMUNICABLE DISEASES

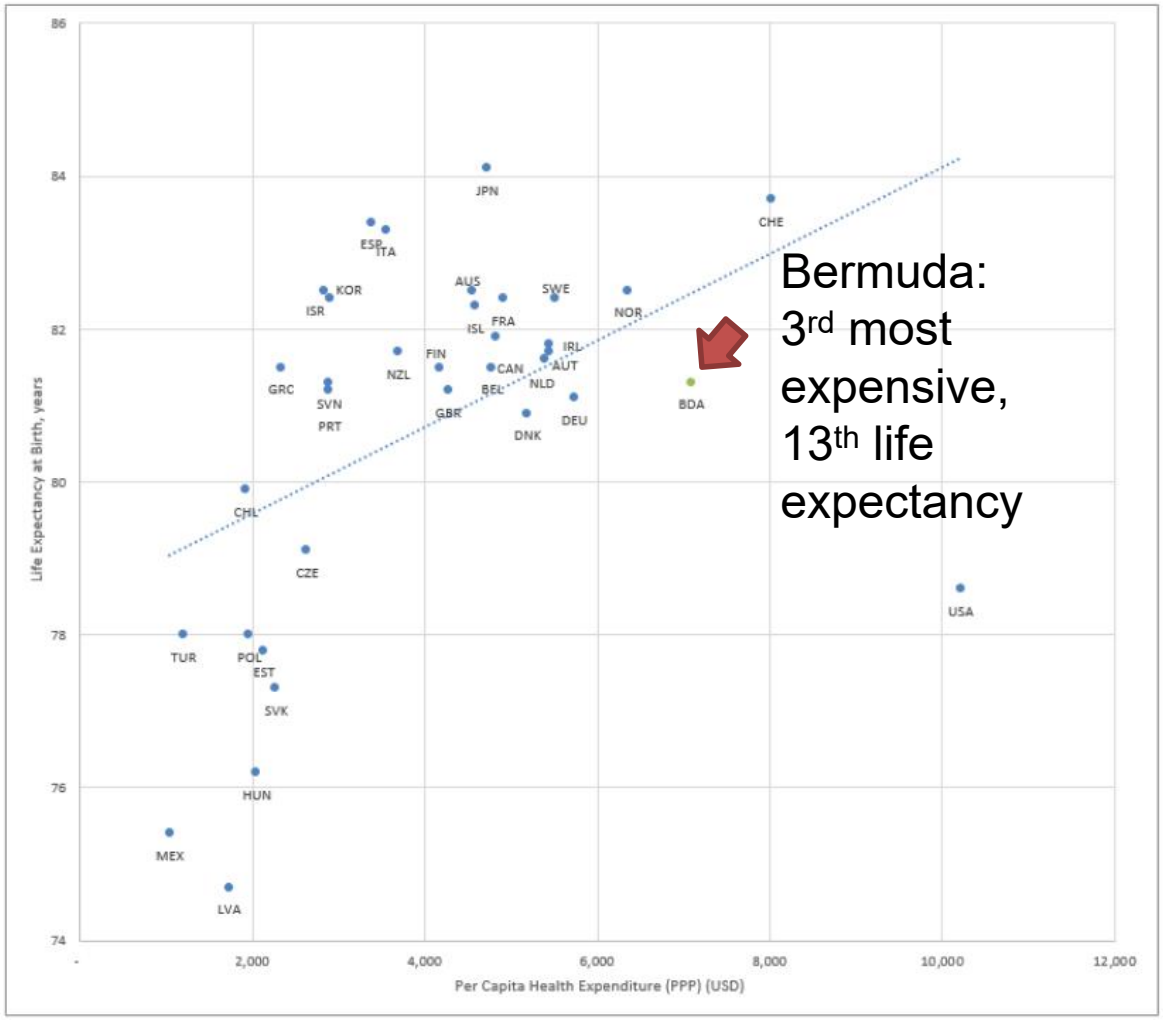
35% of adults have chronic diseases like diabetes, heart disease and kidney disease

HEALTH COSTS

$11,336 spent per person each year

Our health system does not get value for money

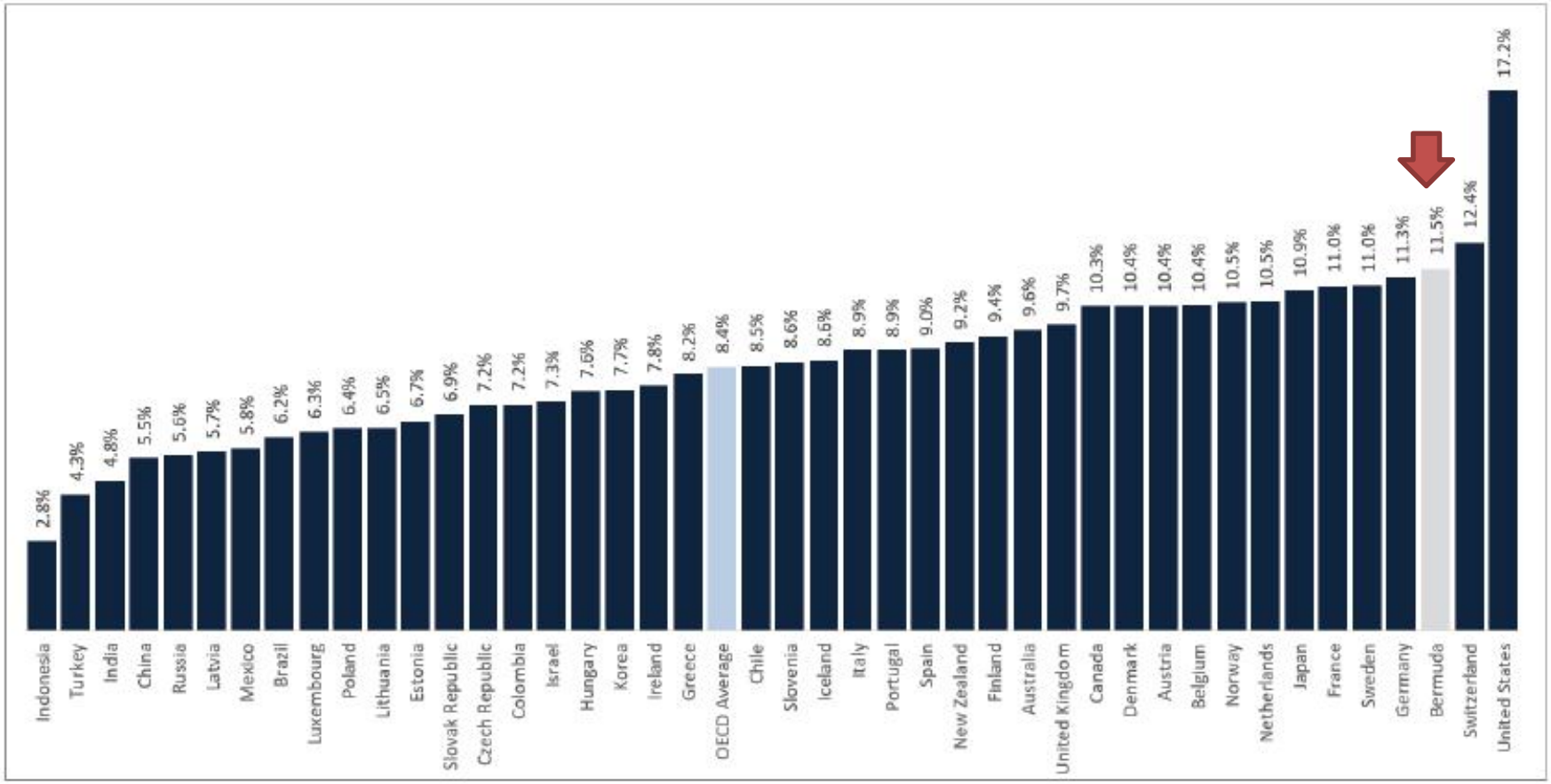
Graph 9. Per Capita Expenditure vs Life Expectancy as a Measure of Health Outcomes



Bermuda: 3rd most expensive, 13th life expectancy

Health costs consume 11.5% of GDP

Graph 8. Health Share of GDP



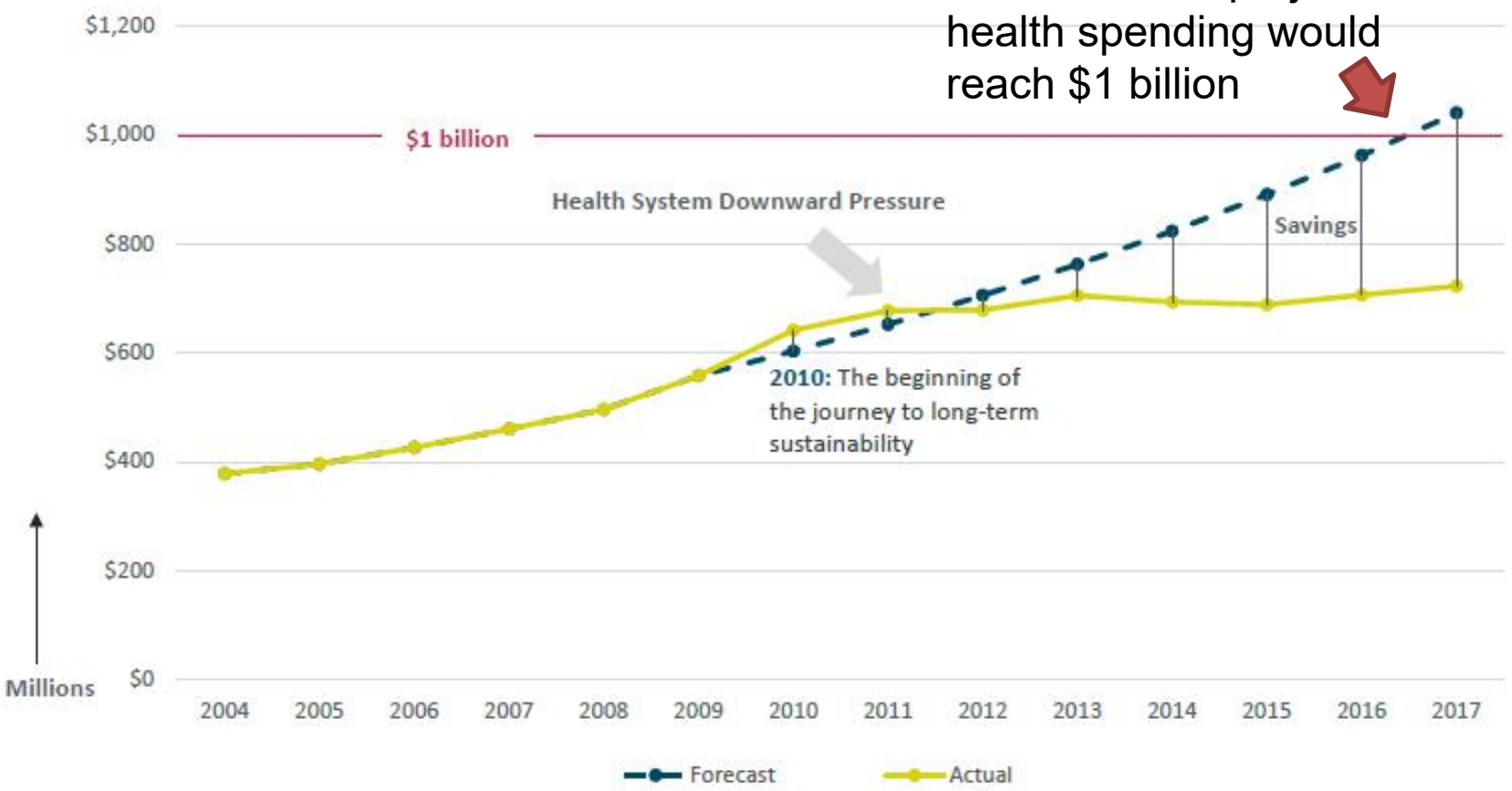
Bermuda has bent the healthcare cost curve and averted at $1 billion fiscal cliff

Figure: 1

Bermuda healthcare expenditures

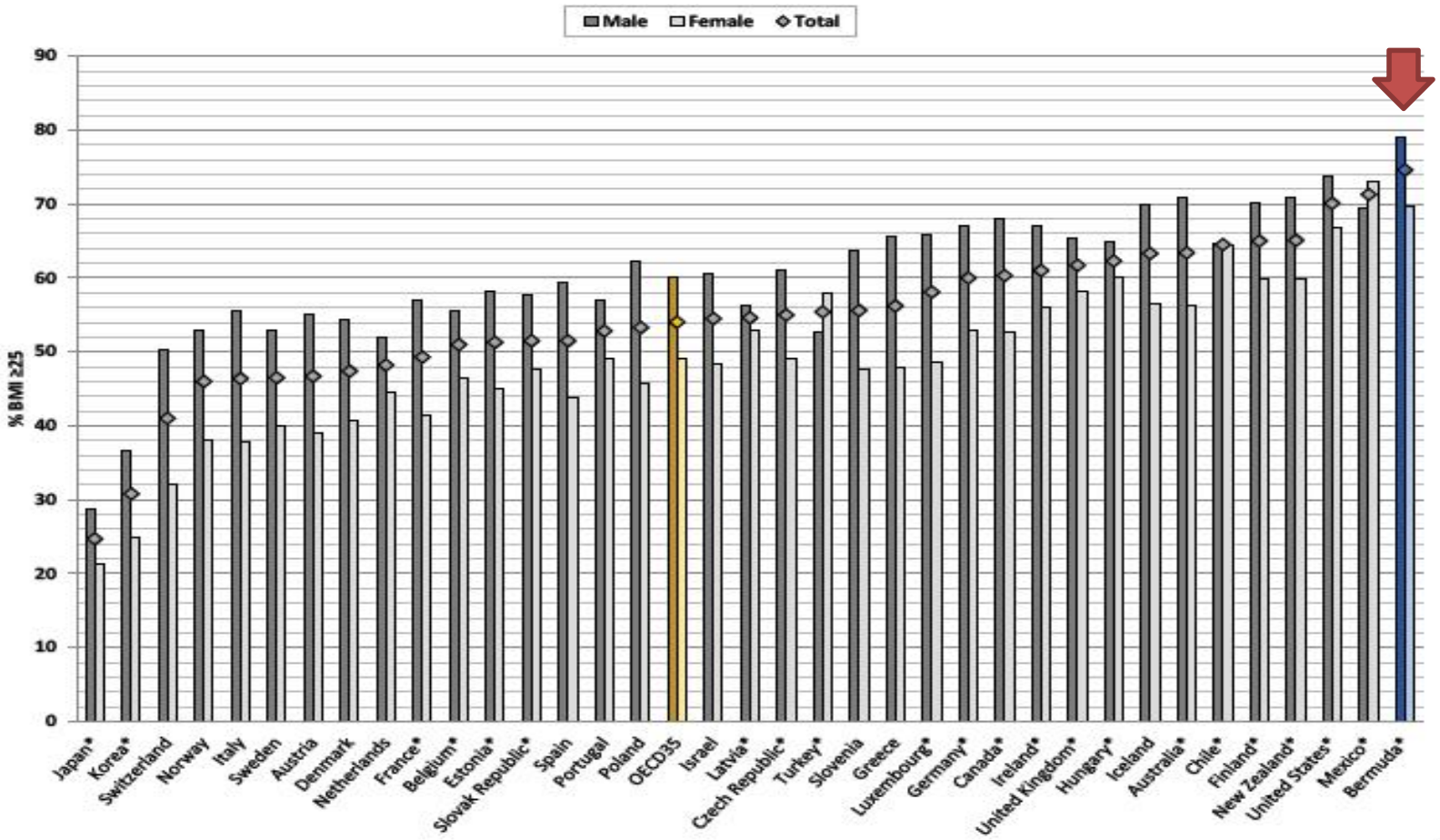
Bermuda Health Council | GOVERNMENT OF BERMUDA Ministry of Health

In 2010 it was projected health spending would reach $1 billion



75% of adults are overweight or obese

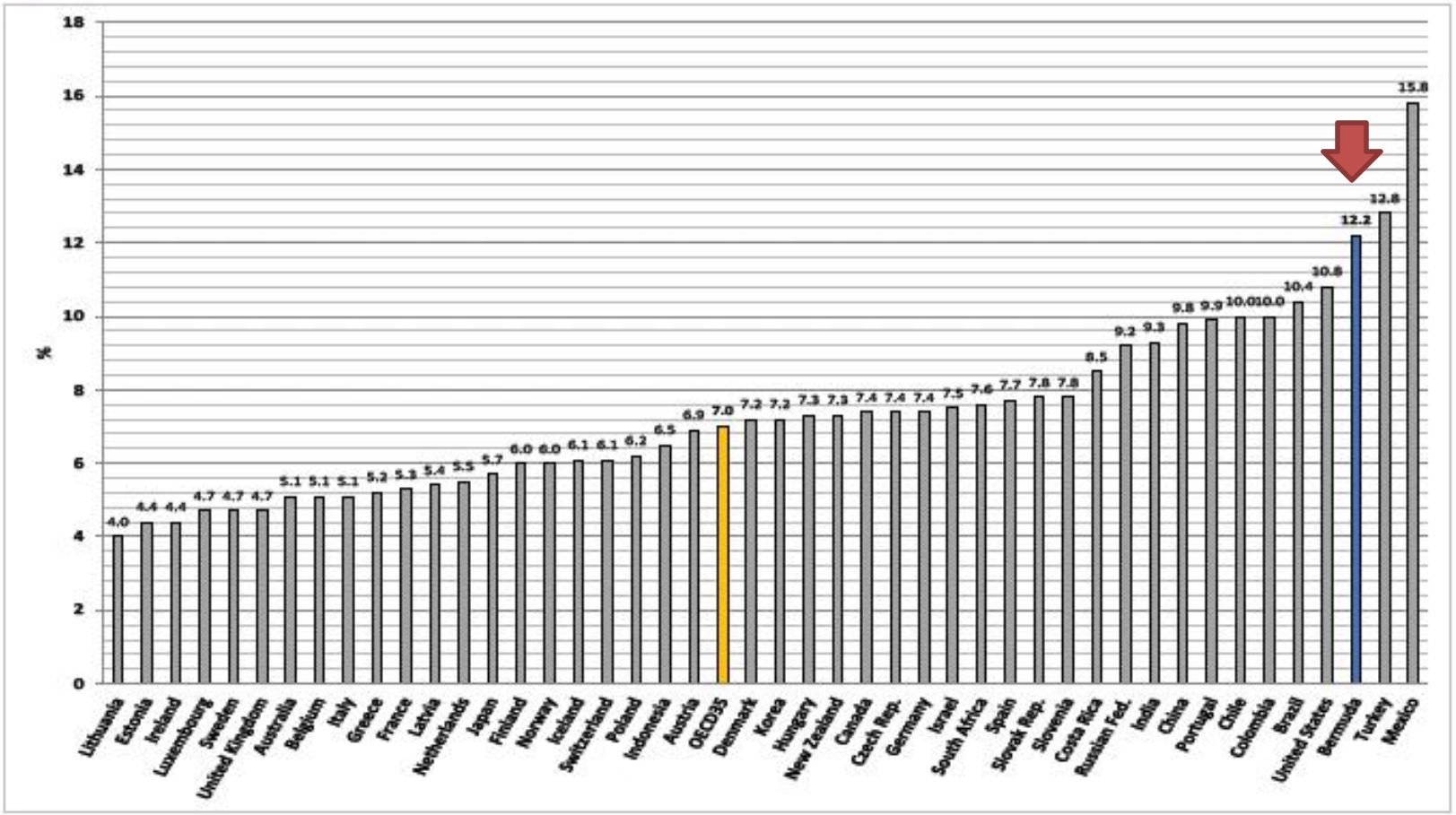
Prevalence of overweight and obesity (BMI 25 and over), OECD Comparison, 2014 (or nearest prior year available)



SOURCE: Health in Review, 2017OECD Health Data 2017

12% of adults have diabetes

Figure 2.5.1 Prevalence of diabetes, OECD Comparison, 2015 (or nearest prior year available)

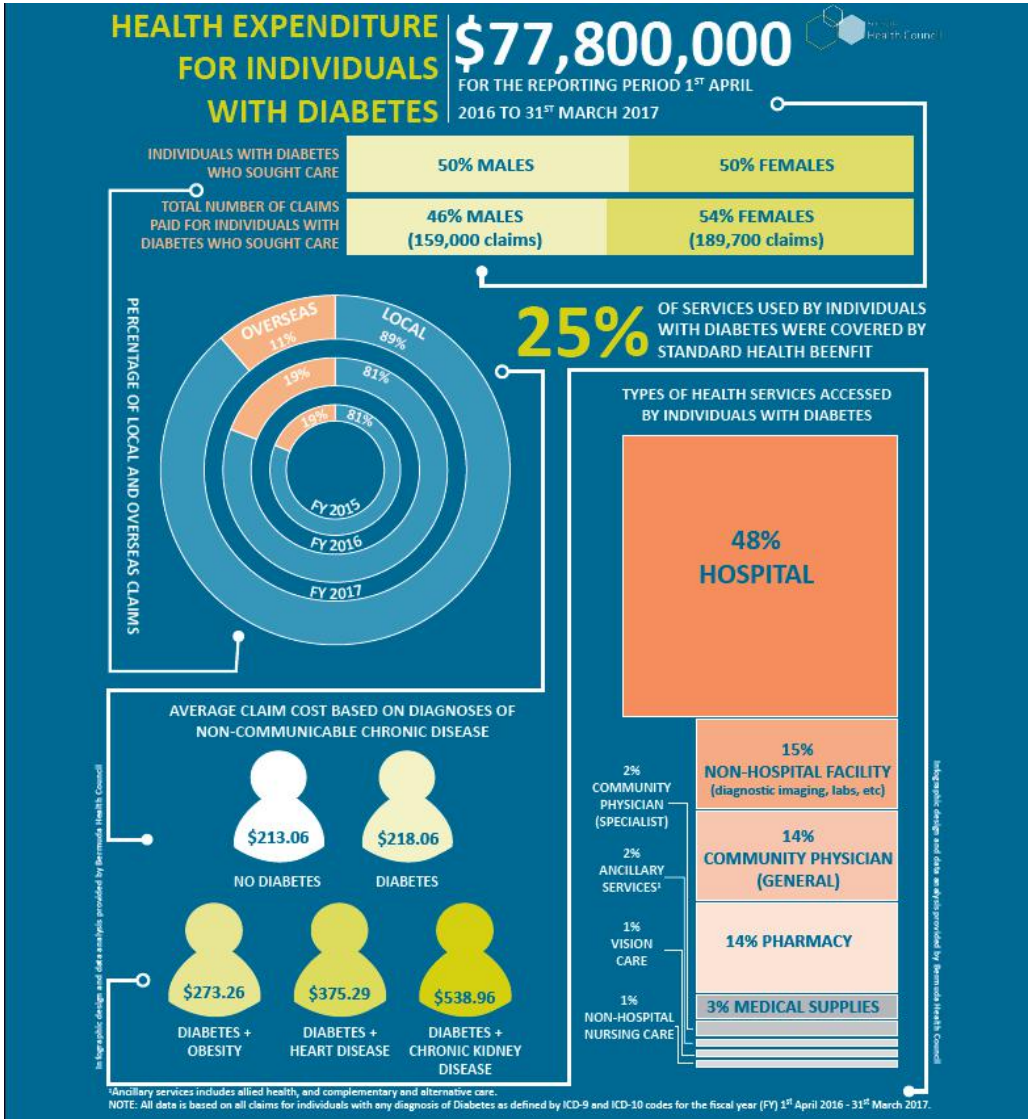


SOURCE: OECD Health Data 2017

54% of Adults have one to two chronic disease risk factors: smoking, low fruit/ veg intake, inactivity, overweight or raised blood pressure

SOURCE: Health Survey of Adults 2014 (STEPS)

$78 million is spent on just 2 preventable conditions. That's 10% of all health spending



SOURCE: BHeC

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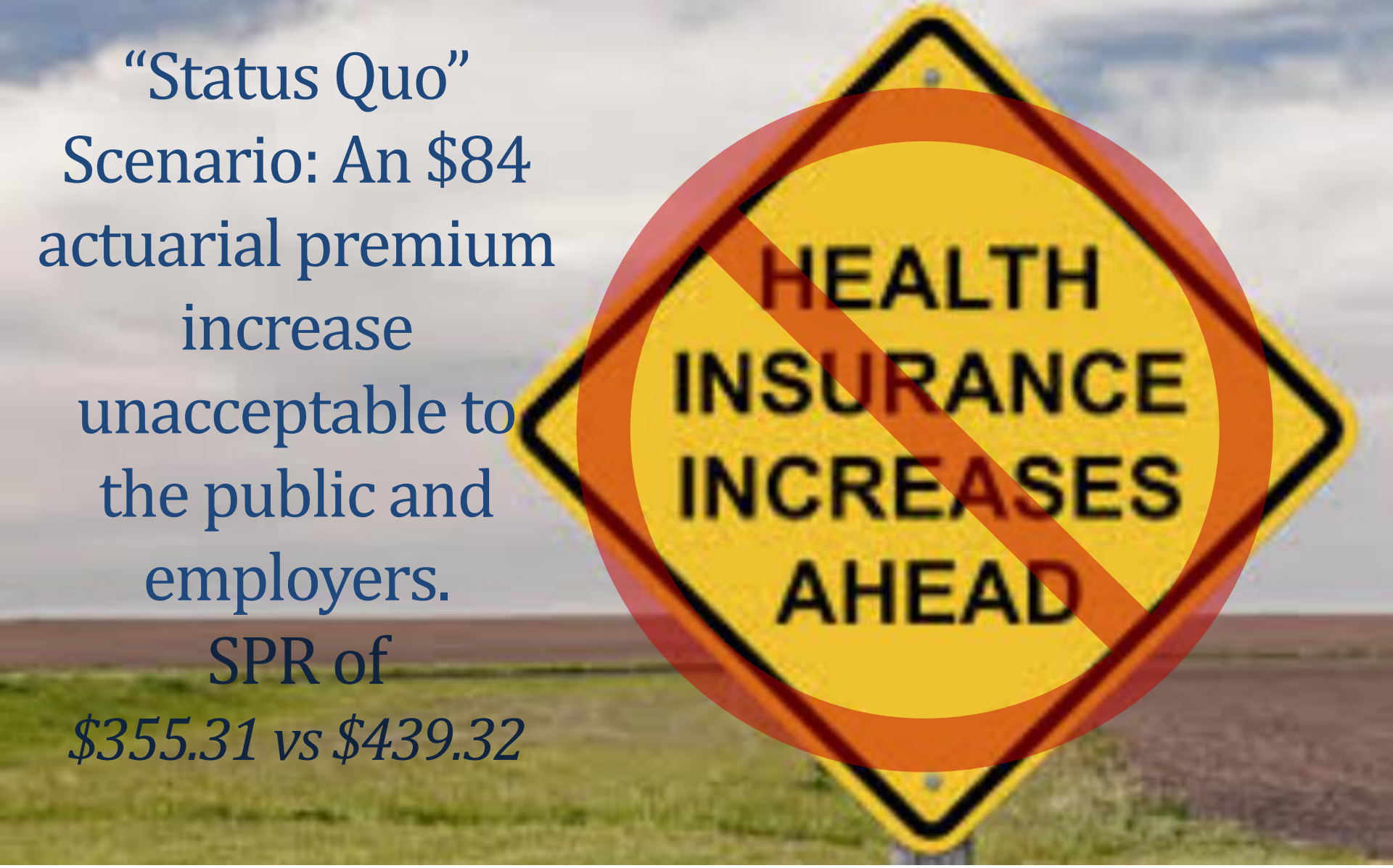
STANDARD PREMIUM RATE 2019

"Status Quo" Scenario: An $84 actuarial premium increase unacceptable to the public and employers.

SPR of

$355.31 vs $439.32



By streamlining the way BHB is funded we protect the standard premium to pay for healthcare only

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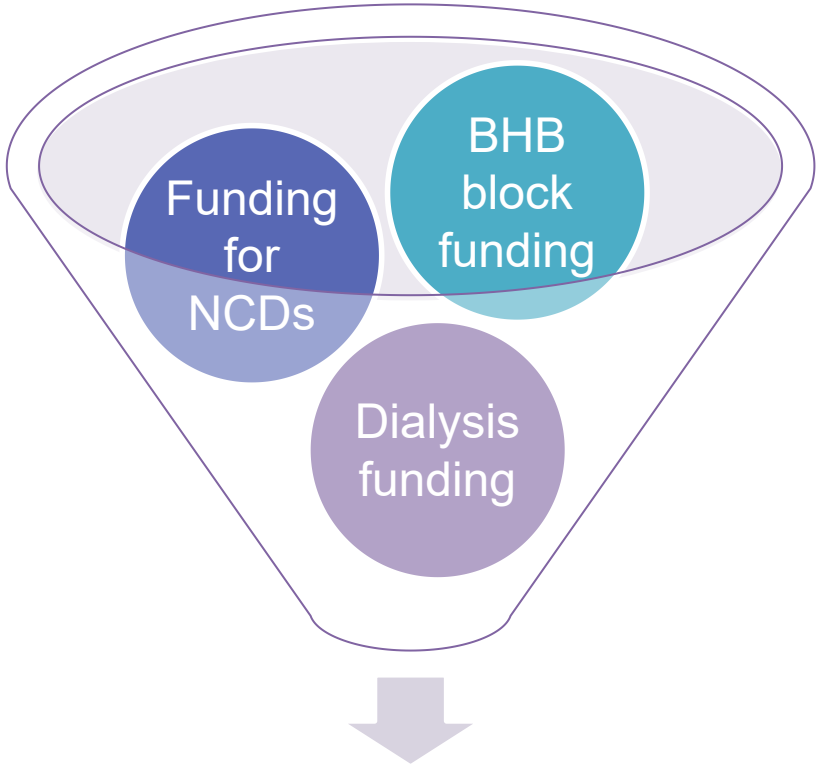
The SPR, HIP and FutureCare premiums will not increase in 2019



No premium increase

Healthcare $ are protected for healthcare

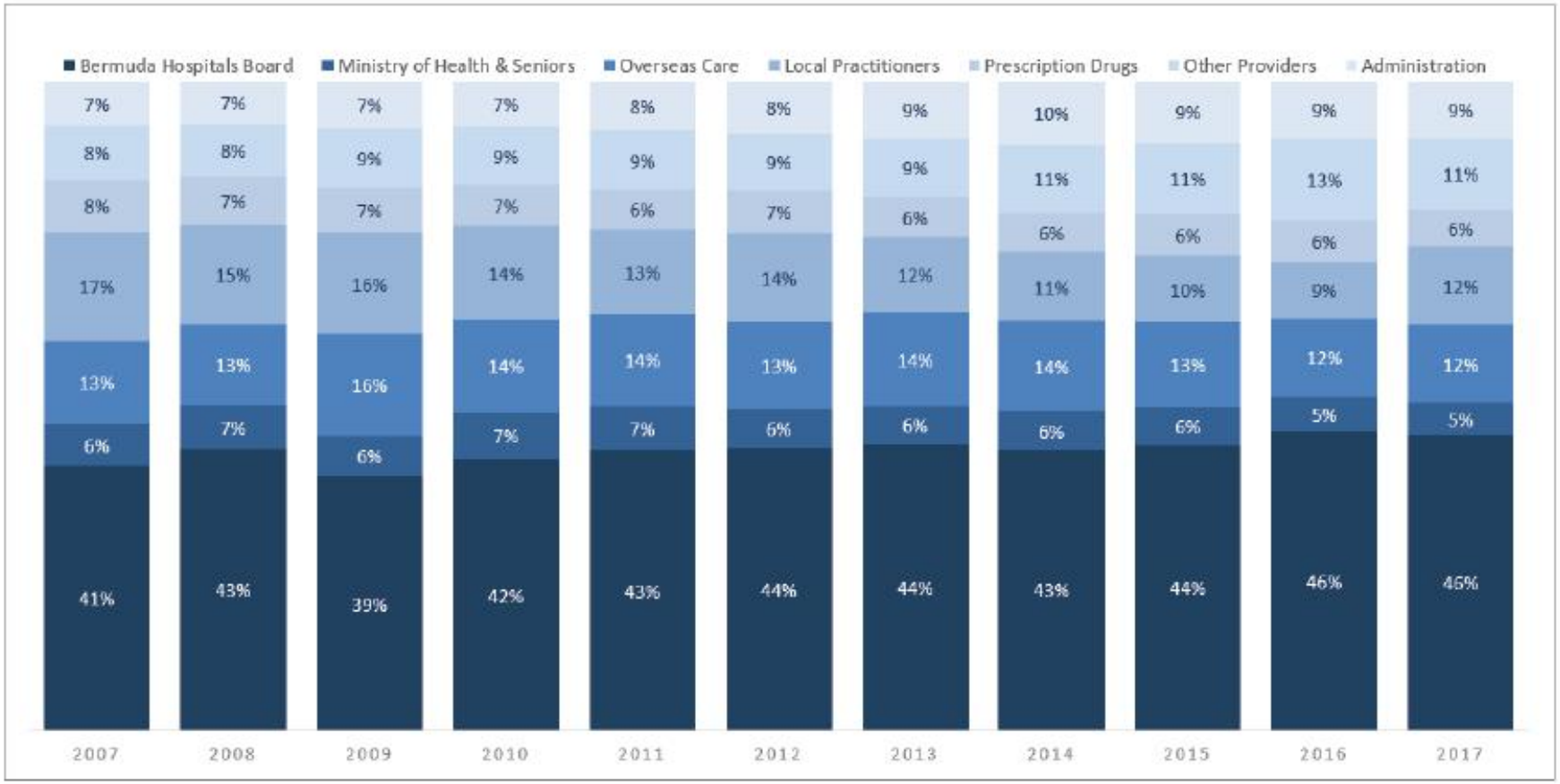
Basic health benefits are kept

Fiscal space for chronic disease benefits

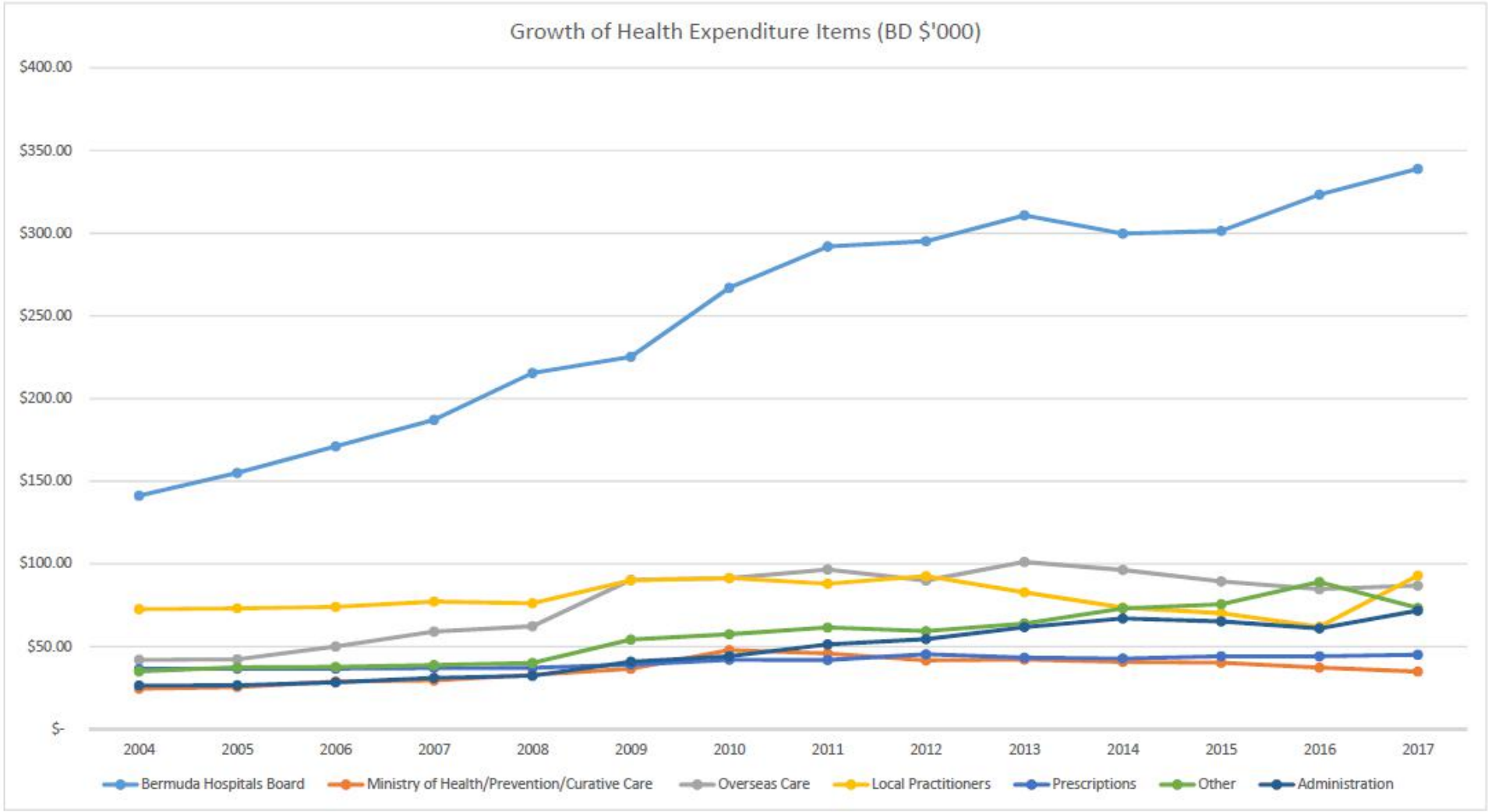
BHB FUNDING CHANGE

46% of health spending is on hospital care and over 95% of SHB/SPR spending

Graph 4. Categories of Health Expenditure



Most components of health spending have been stable over the past 15 years



Currently 4 BHB funding sources

Paying for hospital services

Currently, the Bermuda Hospital Board covers its annual cost through four primary sources:

- Fees charged to public and private insurers for health services rendered (i.e. claims against the Standard Health Premium);
- A Government subsidy grant towards the cost of caring for children, seniors and the indigent;
- A Government grant for the Mid-Atlantic Wellness Institute ("MWI"); and
- A transfer from the Mutual Reinsurance Fund (MRF).

The objective of these various payment mechanisms is to ensure the Bermuda Hospitals Board has sufficient funding to operate the hospital and MWI, and be able to re-invest in necessary building maintenance and technology upgrades.

Moving from paying for volume to paying for value

VOLUME-BASED *(CURRENT)*

Providers are paid for each service they provide to their patients according to the charges determined by their individual practice.

PERFORMANCE-BASED *(TRANSITION)*

Payors reduce fee-for-service payments and use the funds to incentivise providers to achieve certain targets.

VALUE-BASED *(GOAL)*

Providers are paid a set amount per patient, in advance of care. Payment typically has conditions attached.

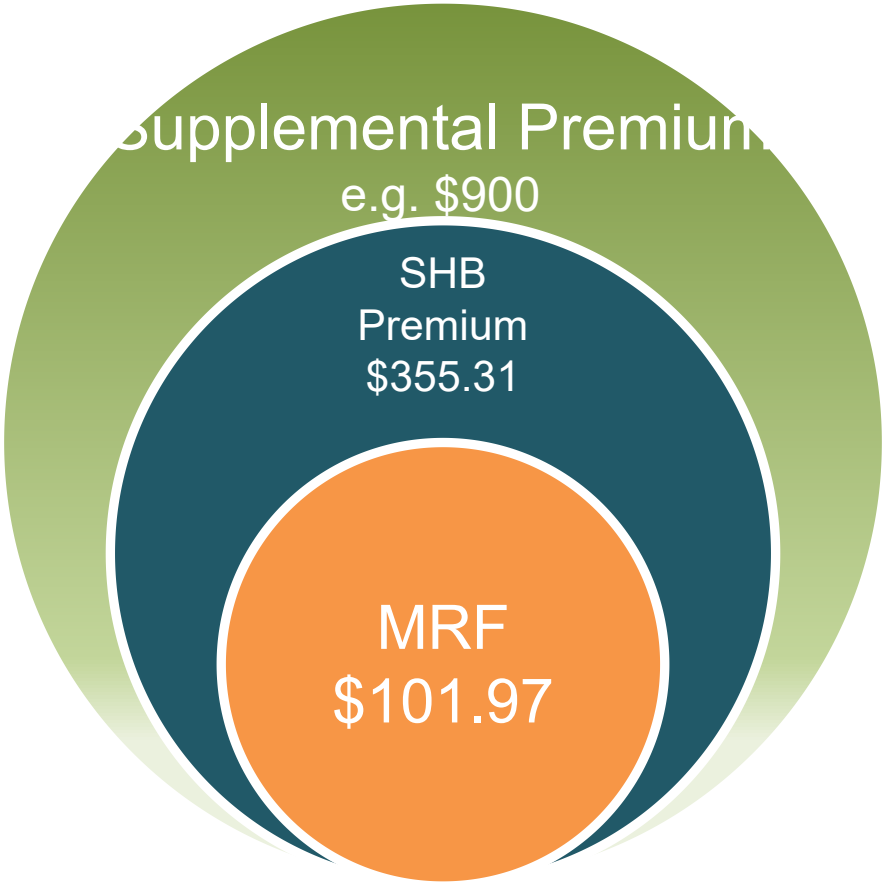
A mixture of payment systems is recommended in any health system to incentivize desired behaviours

The streamlined funding model prevents $20 million added spend and created more opportunity for oversight and utilization review

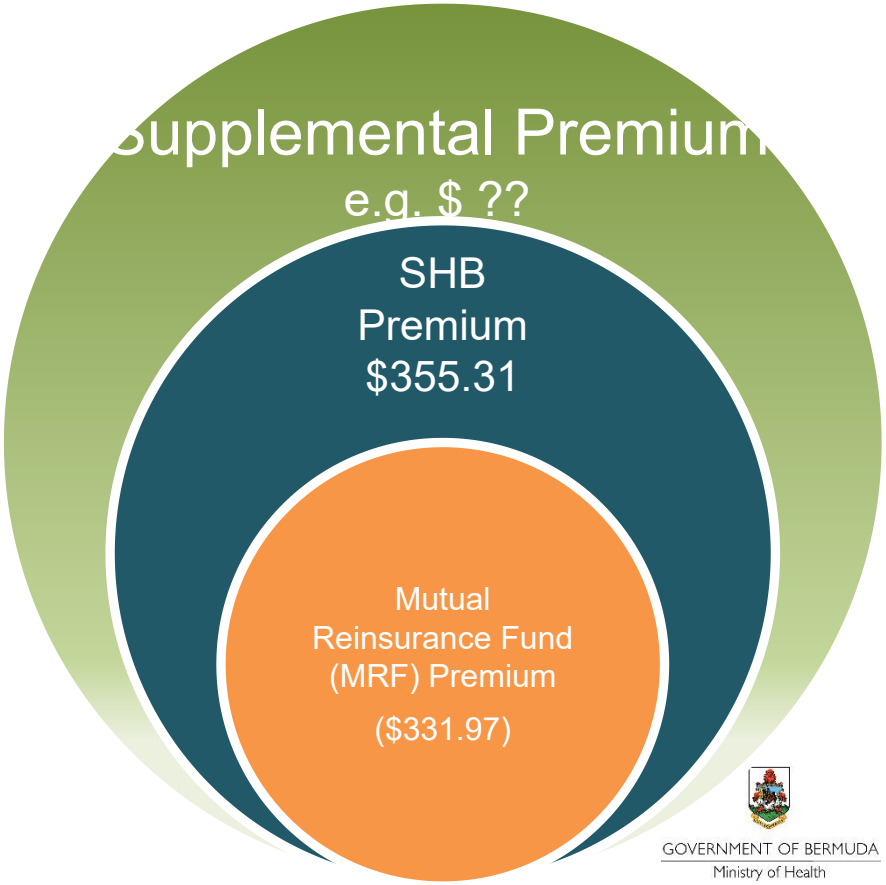
The change in payment mechanism amounts to a $20 million reduction in projected health system costs over the next year. It will enable the expansion of preventive and primary care.

While the standard premium will stay the same, the MRF premium will form a larger part

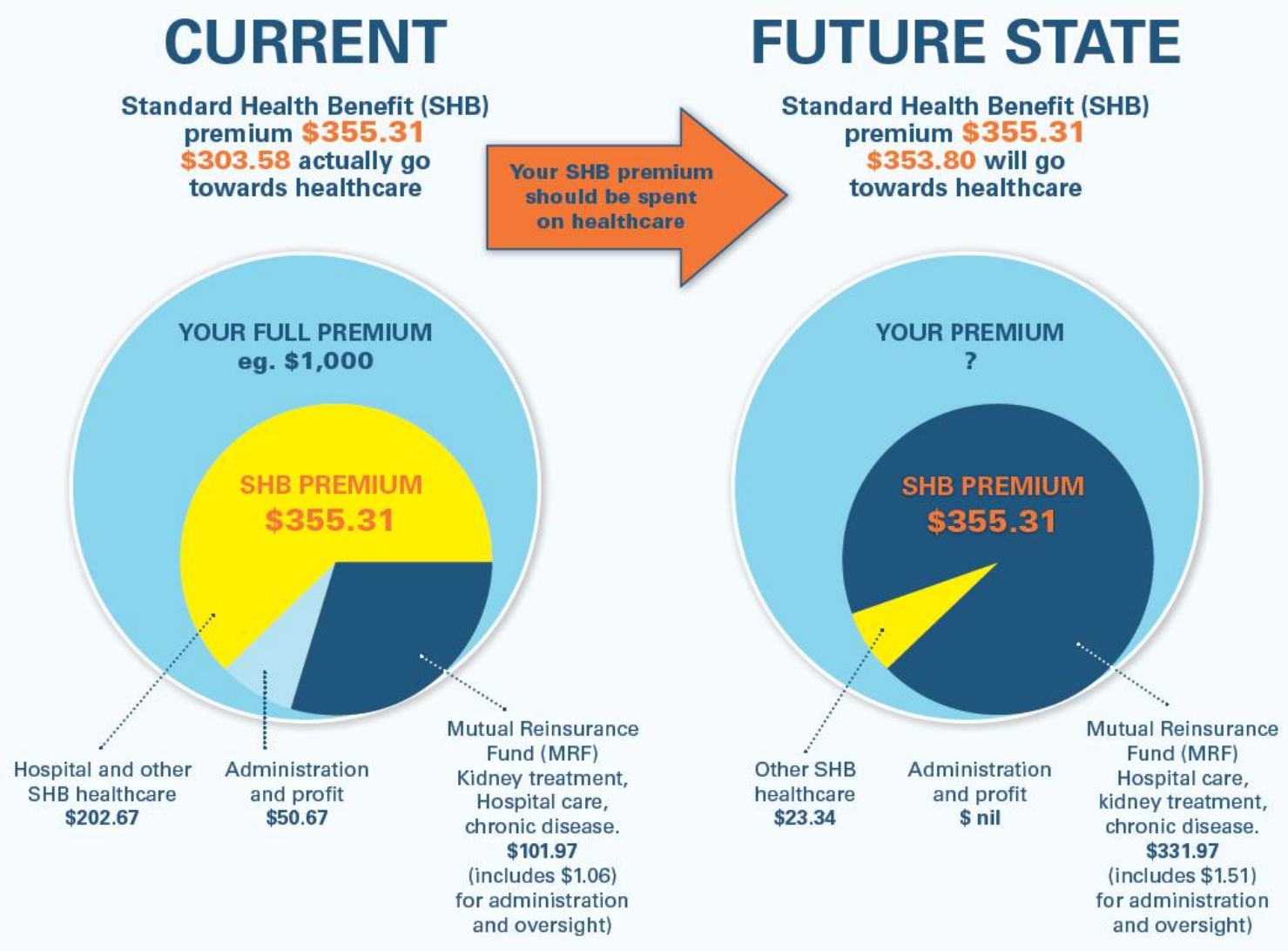
Current premiums



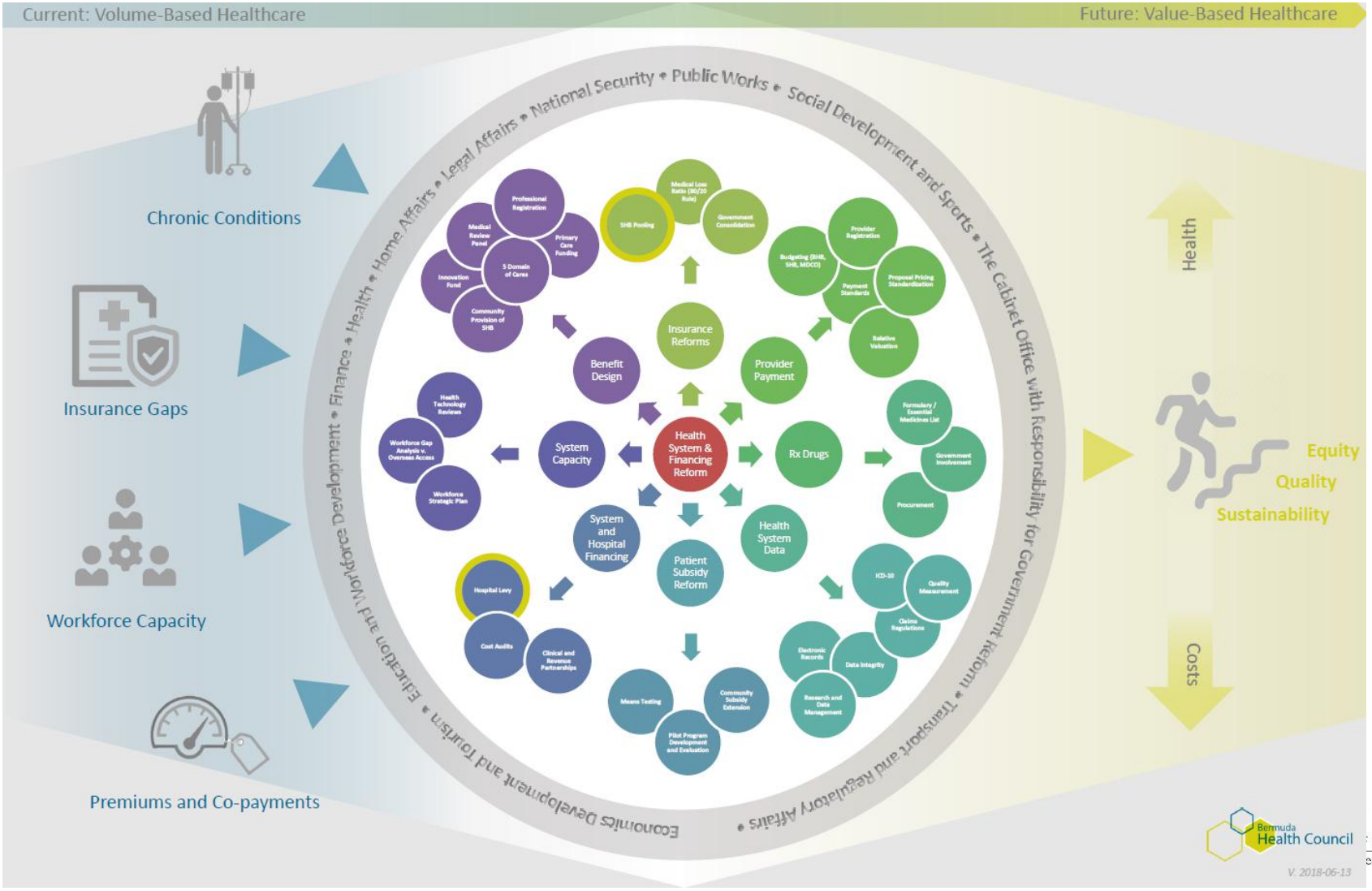
1st June premiums



The new BHB funding system will ensure health premiums only pay for healthcare



To improve health outcomes and lower costs we have to change the way we pay for healthcare



HEALTH FINANCING REFORM

The National Health Plan 2011 started the reform process: a Task Group was appointed to reform health financing, an RFP contracted actuaries and Harvard advisor, and an 'options report' was produced in December 2012

Finance & Reimbursement Task Group

1. Kevin Monkman, MOH
2. Collin Anderson, HID
3. Jennifer Attride-Stirling, BHeC
4. Delia Basden, BHB
5. Dr. Kyjuan Brown, Physician
6. Teresa Chatfield, Business
7. Michael Fisher, Business
8. Nicola O'Leary, Cabinet Office
9. Larry Peck, Insurer
10. Marcelo Ramella, Economics
11. Gerald Simons, Insurer
12. George Spurling, MS
13. Richard Winchell, ABIC
14. Michelle Ye, BHeC Economist

HARVARD SCHOOL OF PUBLIC HEALTH

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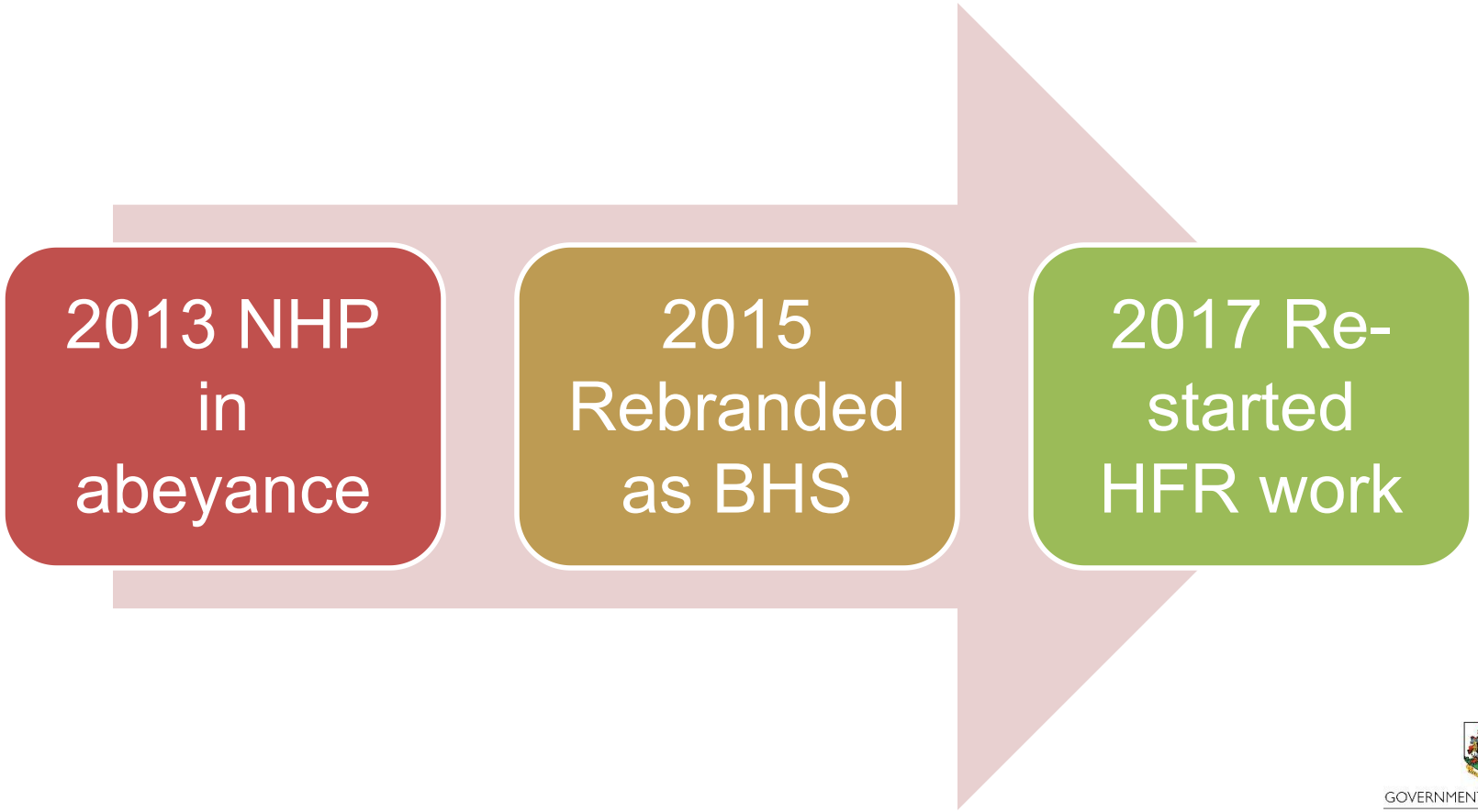
The Government didn't waste time re-inventing the wheel, but chose to use the work of the FRTG to progress health financing reform



In 2012 FRTG considered all possible options to finance healthcare and settled on the two presented as the most viable to achieve the reform goals

Reform Goals

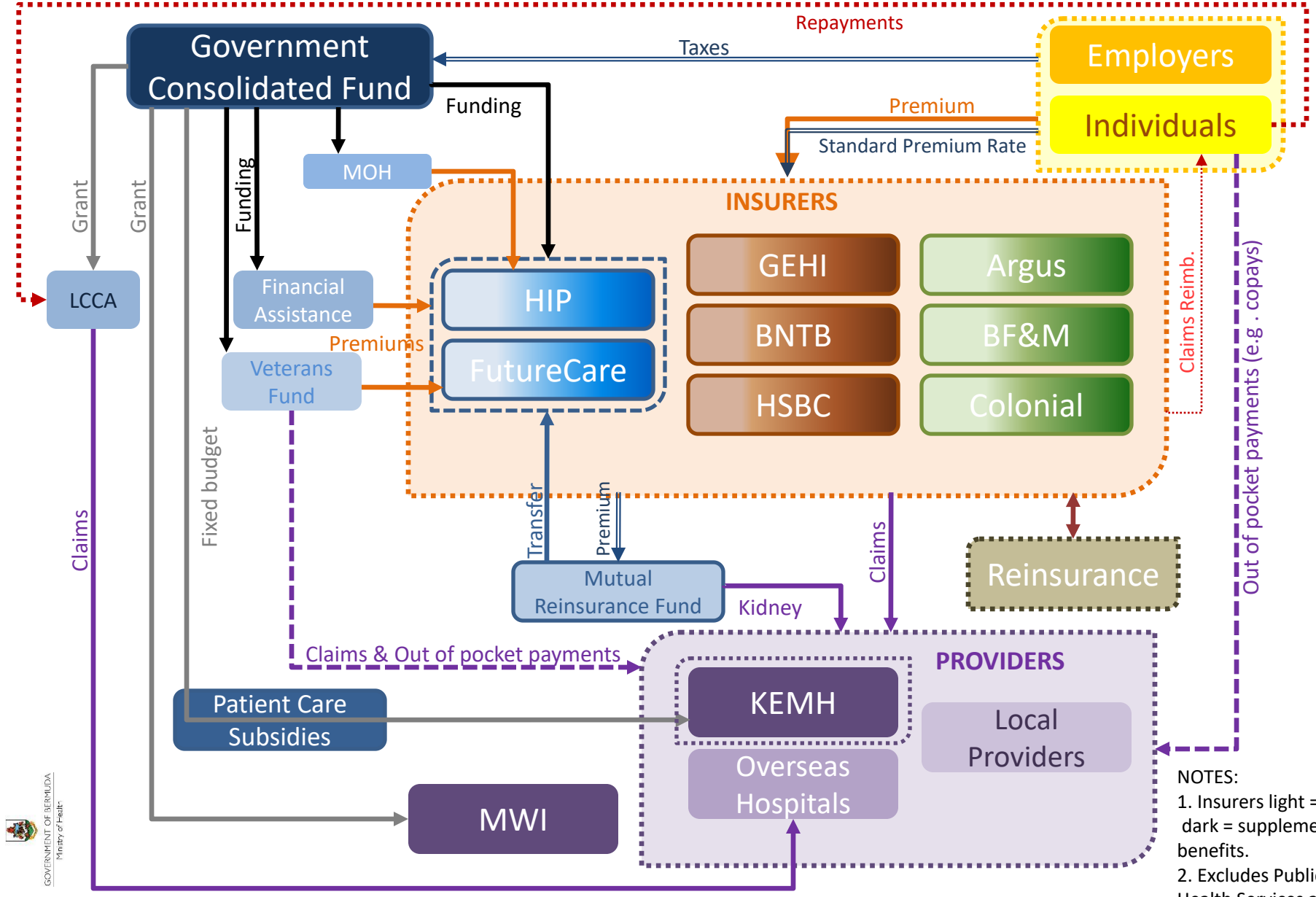
- Universal coverage
- Decent basic package
  - Financial risk protection
  - Prevention and management
- Affordable
- Cost containment

Models Considered

- Medical Savings Accounts
- Individual risk rating
- National Health Service
- Single payer system
- Status quo with guaranteed issue
- Status quo

The 2012 Health Financing Options were developed with consultation and expert advise, considered all possible options, and proposed the most viable models for Bermuda, designed to reduce duplication and increase efficiency

Current Health Insurance Financing System



NOTES:
1. Insurers light = SHB dark = supplemental benefits.
2. Excludes Public Health Services and Residential Care Homes

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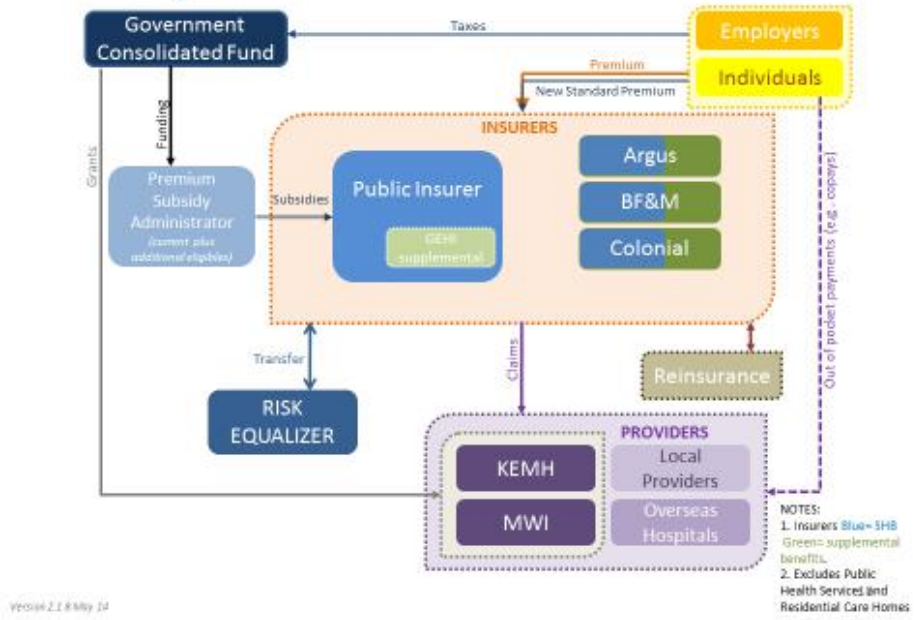
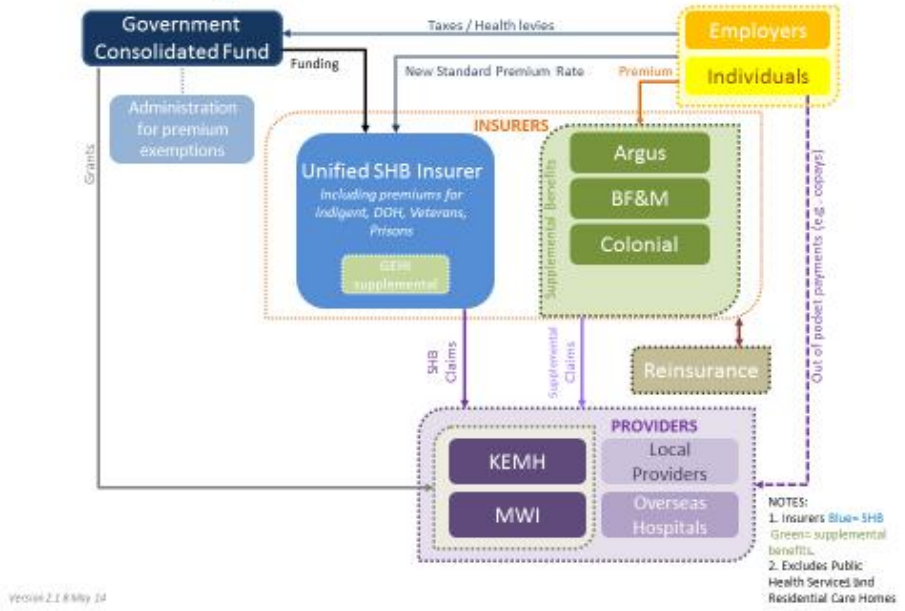
Version 5– Jan2019

Two health financing options were developed that achieve the health system reform goals of efficiency, sustainability and improved healthcare access

Dual System



Unified System



Both options improve on the current system and achieve universal coverage

Feature	Current System	Unified System	Dual System
Universal Coverage	×	✓	✓
Uniform Minimum Package of Benefits	✓	✓	✓
Guaranteed Issue	×	✓	✓
Community Rating for Minimum Package	✓	✓	✓
Existence of Public Insurance Pool	✓	✓	✓
Existence of Private Insurance Pools	✓	Supplemental Only	✓
Size of Risk Pools	Various	One pool	Various
Funding (non-government)	Premiums	Premiums and Other	Premiums
Government Funding	✓	✓	✓
Cross Subsidy in Funding	✓	✓	✓
Risk Management	✓ (e.g. MRF and reinsurance)	✓ (e.g. reinsurance)	✓ (e.g. transfer mechanism, reinsurance)
Reimbursement of Providers	Fee-for-service for Outpatient and a fee based on a Diagnostic Related Group (DRG) for Inpatient	Fee-for-service, DRG and Other	Fee-for-service and DRG

To improve health outcomes, access, and lower costs we have to change the way we pay for healthcare

The HFR initiative is led by the Ministry supported by the Health Council a Steering Committee, and a Stakeholder Consultation Group

MINISTER OF HEALTH

Directs Policy

HFR STEERING CO

Assesses and ac

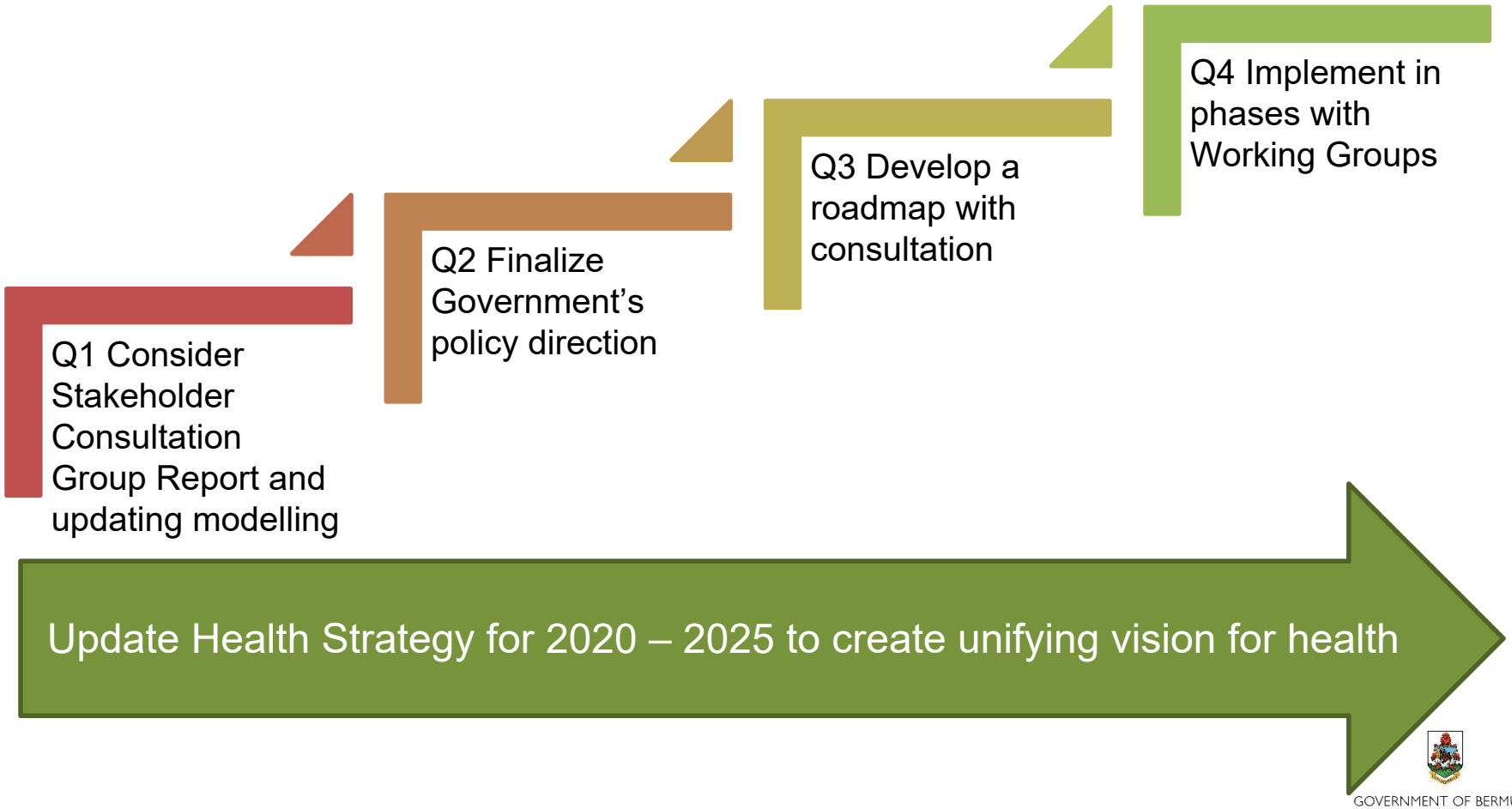
BHeC

Technical support

STAKEHOLDER CONSULTATION GROUP

Stakeholder perspective, input and feedback

Next steps in health financing reform



THANK YOU

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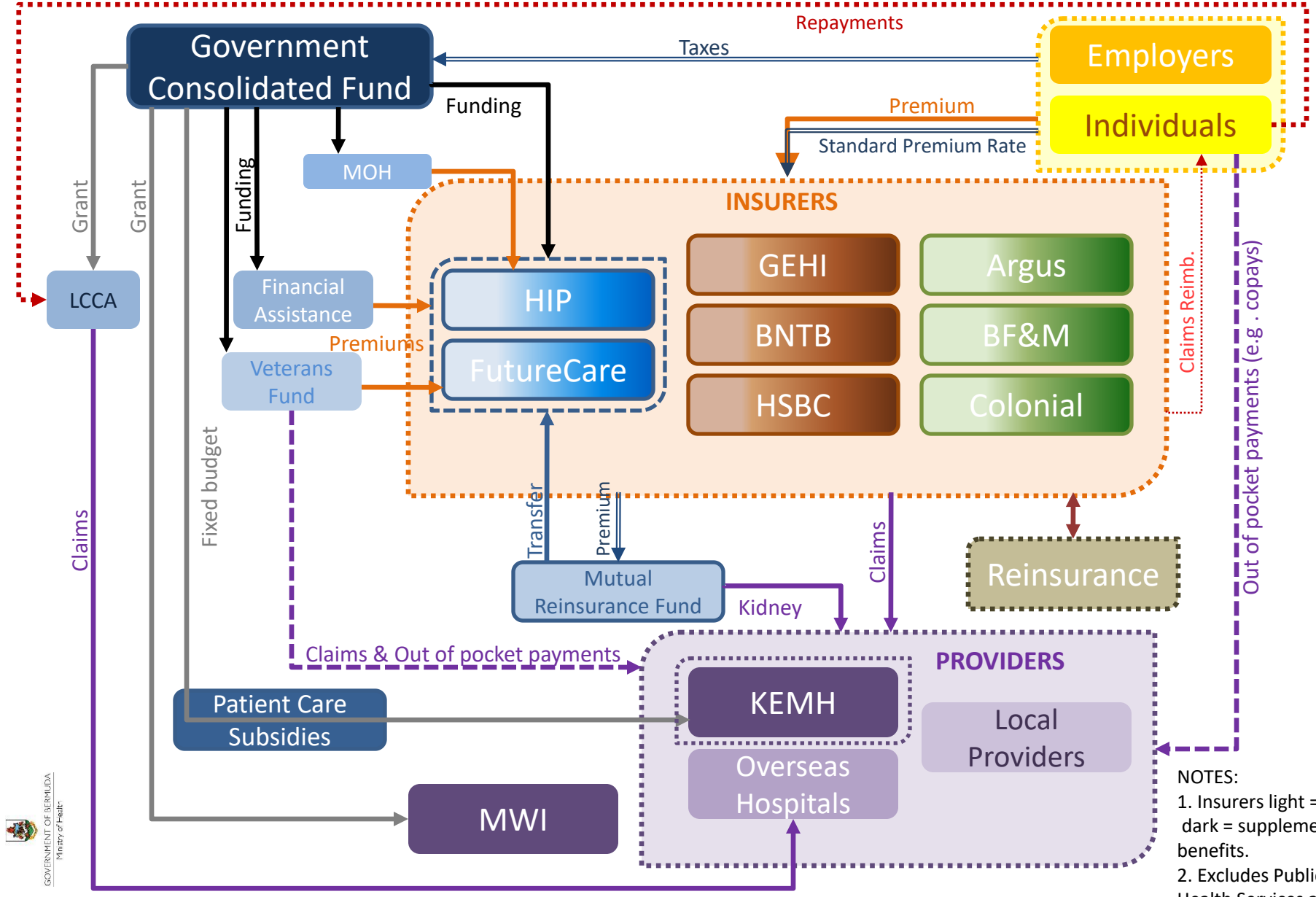
Current Health Insurance Financing System



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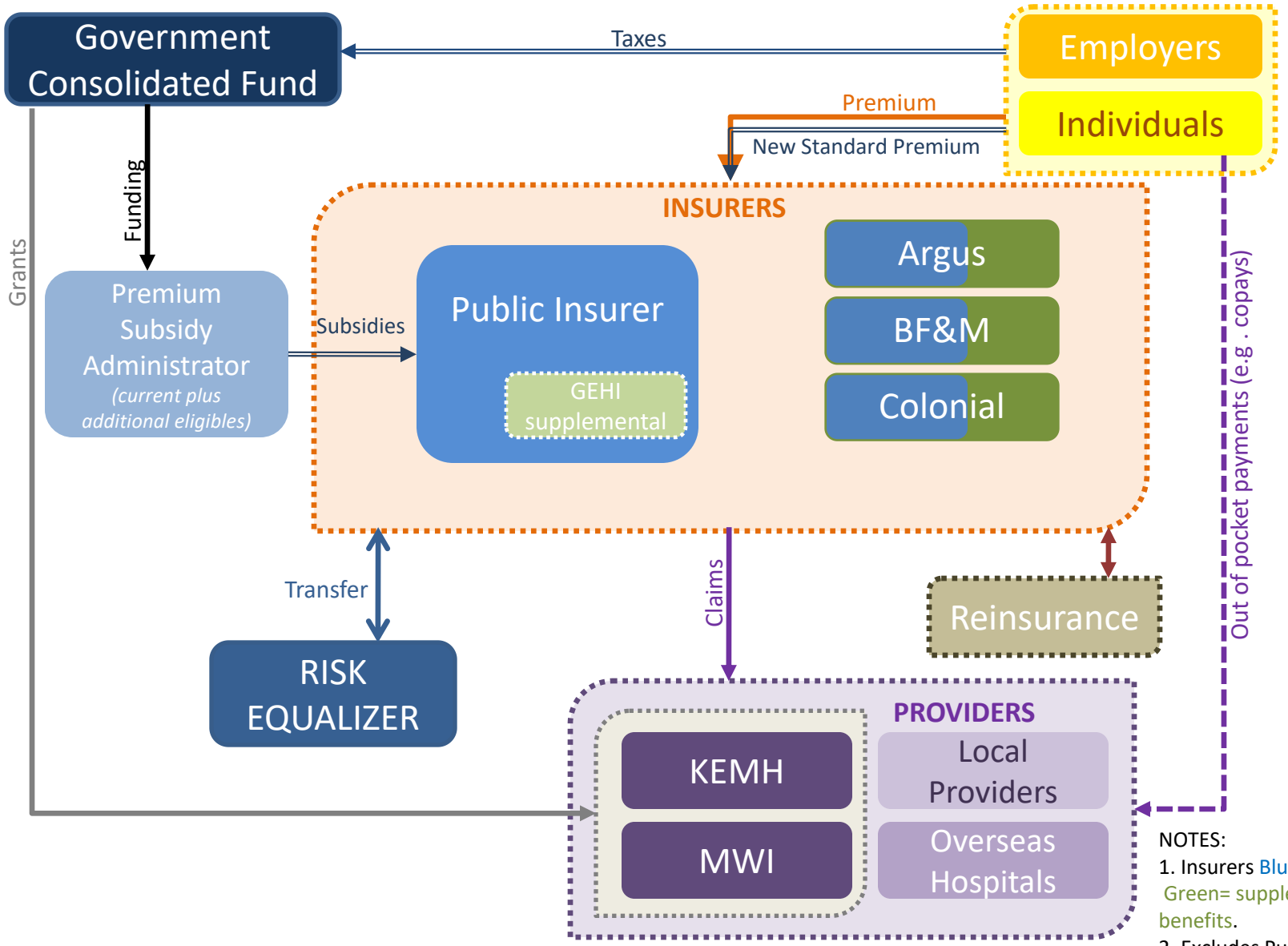
Government Consolidated Fund
Taxes
Employers
Individuals
Premium
New Standard Premium
Funding
Grants
INSURERS
Premium Subsidy Administrator
(current plus additional eligibles)
Subsidies
Public Insurer
GEHI supplemental
Argus
BF&M
Colonial
Transfer
RISK EQUALIZER
Claims
Reinsurance
Out of pocket payments (e.g . copays)
PROVIDERS
KEMH
MWI
Local Providers
Overseas Hospitals
NOTES:
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Green= supplemental benefits.
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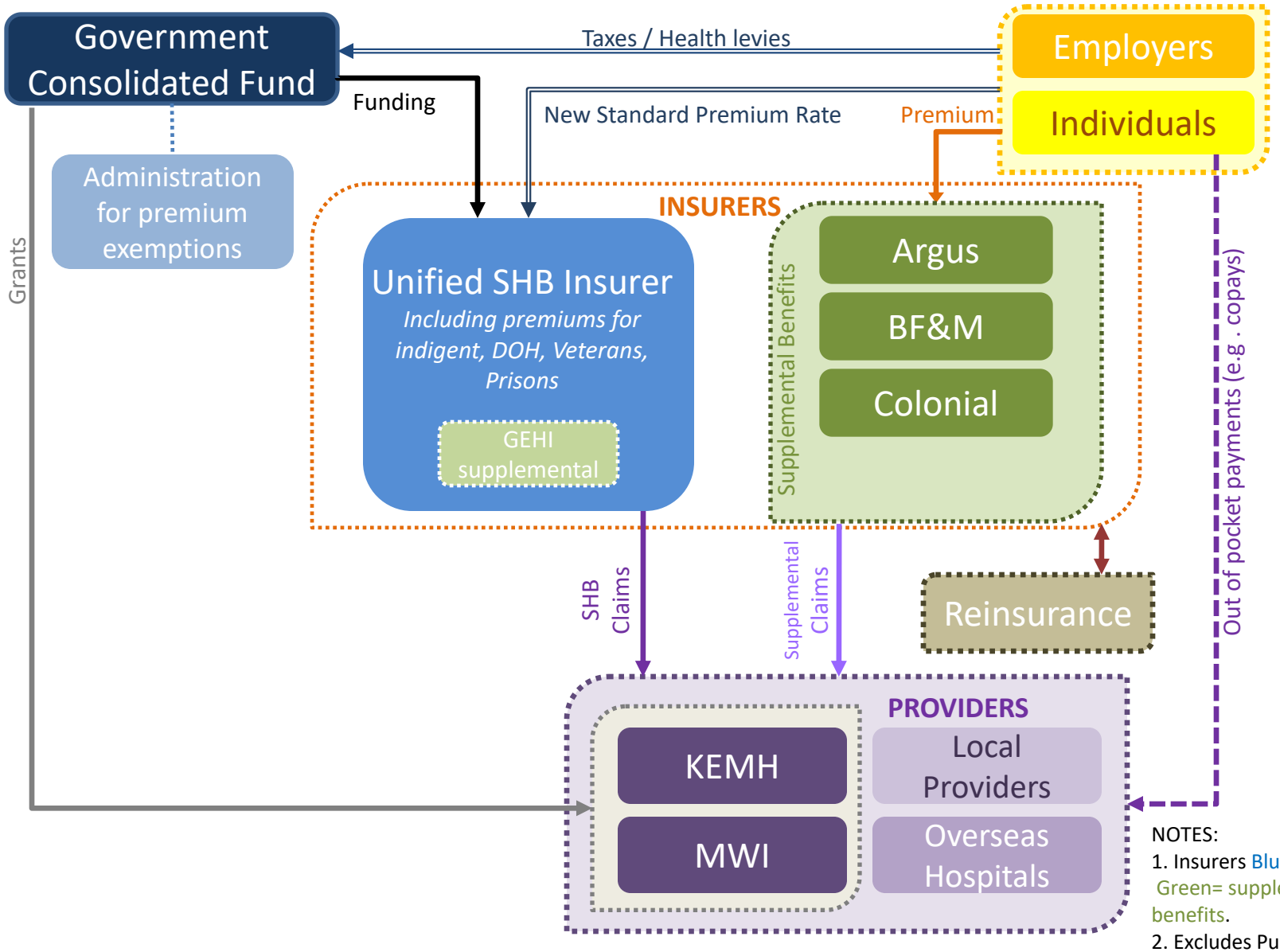

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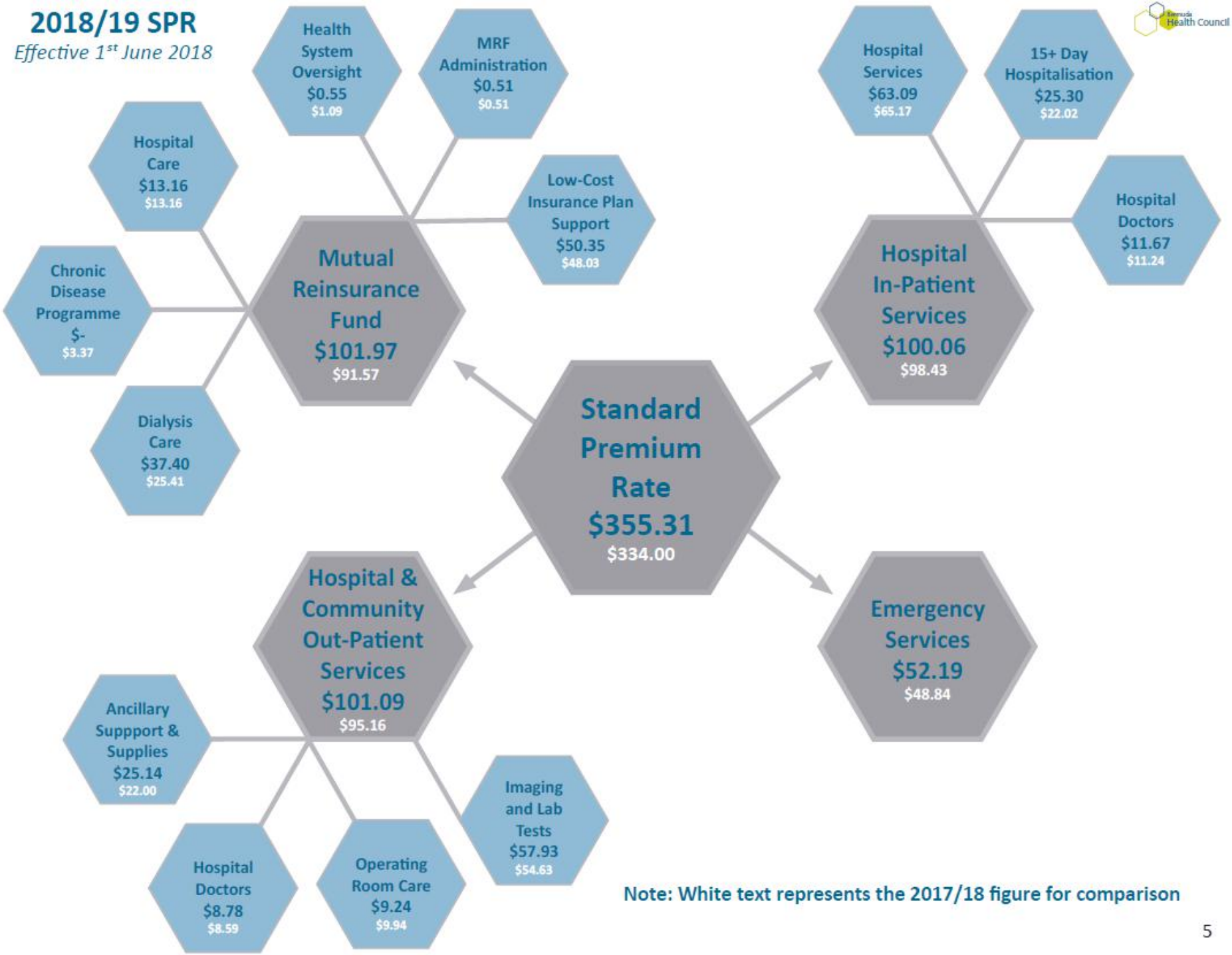
Version 2.1 8 May 14

2018/19 SPR

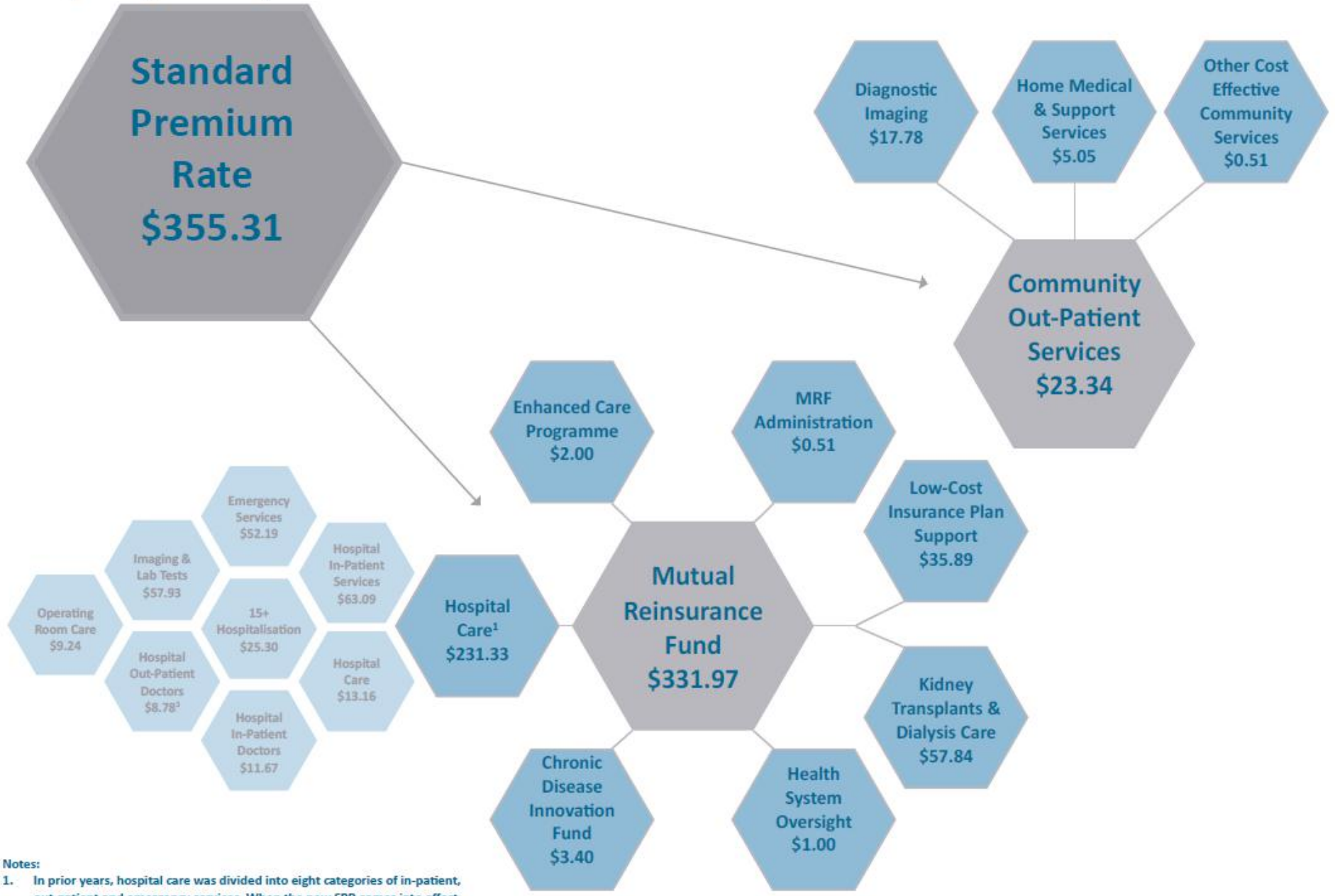
Effective 1st June 2018



Note: White text represents the 2017/18 figure for comparison

2019/20 SPR

Anticipated effective date, 1st June 2019



Notes:

1. In prior years, hospital care was divided into eight categories of in-patient, out-patient and emergency services. When the new SPR comes into effect, all hospital care will be covered by a single MRF transfer of $231.33, compared to a cumulative SPR-related income of $241.36 in 2018/19.