



# **Enhancing the Regulatory Framework for Health Insurers**

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PUBLIC CONSULTATION PAPER

Bermuda Health Council

July 2010

# Enhancing the Regulatory Framework for Health Insurers

Public Consultation Paper

**Contact us:**

If you would like any further information about the Bermuda Health Council, or if you would like to bring a healthcare matter to our attention, we look forward to hearing from you.

**Mailing Address:**

PO Box HM 3381,  
Hamilton, HM PX, Bermuda

**Street Address:**

Sterling House, 3rd Floor, 16 Wesley Street,  
Hamilton, HM11, Bermuda  
Phone: 292-6420  
Fax: 292-8067  
Email: [bdahealthcouncil@bhec.bm](mailto:bdahealthcouncil@bhec.bm)

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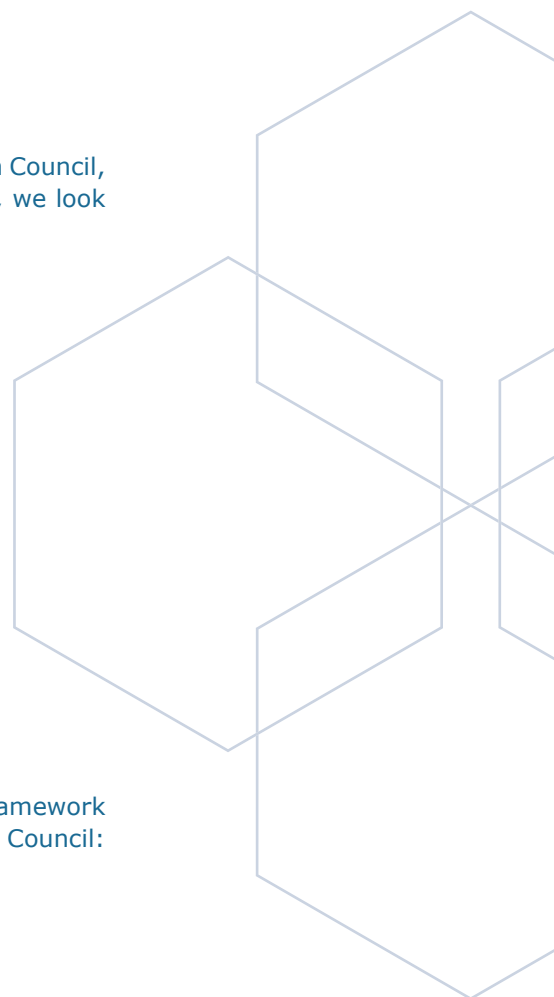
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## I. Executive Summary

1. The purpose of this consultation paper is to disseminate the conceptual framework of the Bermuda Health Council's (BHeC) proposed enhancements and reforms to legislation and regulations concerning health insurers in Bermuda.
2. The BHeC's *Strategic Plan 2009-2012* identifies enhancing the regulation of health services, health professionals and health insurers as a strategic objective. Our *Corporate Plan 2010-2011* sets "collaboration with the Ministry of Health (MoH) to enhance the regulatory framework for health insurers" as a priority objective for the 2011 fiscal year.
3. There are several key demographic, economic, and health trends for Bermuda that highlight the need to enhance the regulatory framework for health insurers. A sustainable healthcare system requires a robust and appropriately regulated health insurance sector which serves the best interest of the public.
4. Prominent among the trends is the current high rate of growth of health care expenditure in Bermuda (8.8% per annum) and the growing financial burden it presents, both to individual insureds and to the government. Analysis of the drivers behind these trends by the BHeC focused our attention on three issues that are critical to safeguarding the island's ability to adequately finance health care in the future:
  - i. Prudential regulation of health insurers
  - ii. Population demographics
  - iii. The predominance of group insurance and the resulting difficulty for some individuals to obtain affordable private coverage.
5. Potential problems arising from these key issues were the impetus for the proposed reforms. The proposed reforms are designed to achieve three primary goals, each of which has its own objectives. They are to:
  - i. Protect the public
    - Ensure financial solvency of insurers.
    - Ensure transparency and fairness in the contractual relationship between the health insurer and insureds.
    - Ensure that health insurance packages provide adequate financial protection.
  - ii. Promote equity
    - Minimize adverse selection against health insurers and ensure adequate insurance coverage for all residents of Bermuda.
    - Mandate premium setting policies that promote cross-subsidies between healthy and sick and between income levels.

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- iii. Promote cost efficiency
    - Ensure accurate and prompt reimbursement of providers.
    - Encourage adoption of robust information technology systems in order to move towards 100% electronic claims processing.
  6. The BHeC believes there are several benefits to health insurers from the proposed reforms. Among these are lower financial risk, diminished risk of adverse selection and moral hazard, more diverse risk pools, lower underwriting costs, and increased transparency; all of which will promote operational efficiency and innovation.
  7. We welcome questions and comments, and invite feedback from health insurers, employers, healthcare professionals, financial and economic analysts, and the public on the legislative and regulatory initiatives proposed in this consultation paper.

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## II. Introduction

### Purpose of the Consultation Paper

8. The purpose of this consultation paper is to disseminate to health insurers (defined here as licensed health insurance companies, approved schemes, and licensed health insurance plans), to health professionals, employers and the public, the Bermuda Health Council's (BHeC) proposed reforms to the regulatory framework for health insurers. The paper also seeks to inform all health system stakeholders, employers, and the general public of our health insurance regulatory reform initiatives. The consultation paper is the promised follow-up to the BHeC consultation meeting held with members of the Health Insurance Association of Bermuda (HIAB) on March 24<sup>th</sup>, 2010. This paper outlines in greater detail the key policy goals and objectives of the regulatory reform initiatives presented for discussion at that meeting.

### Background

9. The BHeC's *Strategic Plan 2009-2012*<sup>1</sup> identifies enhancing the regulation of health services, health professionals and health insurers as a strategic objective. Our *Corporate Plan 2010-2011*<sup>2</sup>, which is aligned with the long run objectives outlined in the strategic plan, sets "collaboration with the Ministry of Health (MoH) to enhance the regulatory framework for health insurers" as a priority objective for the 2011 fiscal year. The Ministry of Health has reviewed the recommended policy goals and objectives that we present in this consultation paper, and concurs with, and endorses those recommendations. The Ministry's endorsement was given in the public interest in accordance with the Bermuda Health Council Act 2004, Part II, and section 7.
10. The BHeC also consulted with the Ministry of Finance (MoF) and the Bermuda Monetary Authority (BMA) on the direction and scope of the proposed reform initiatives. Both institutions generally supported the policy goals and objectives as presented by the BHeC.
11. The BHeC's strategic goals are quality, equity, efficacy, and accountability in the delivery of health care services in Bermuda. Achievement of these goals is imperative if Bermuda is to have a sustainable health care system.

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<sup>1</sup> Bermuda Health Council. (2009). Quality and Sustainability in Healthcare: Bermuda Health Council, Strategic Plan 2009-2012. Retrieved May 27, 2010 from <http://www.bhec.bm/resources/docs/Strategic%20Plan.pdf>

<sup>2</sup> Bermuda Health Council. (2009). Bermuda Health Council, Corporate Plan 2010-2011. Retrieved May 27, 2010 from <http://www.bhec.bm/resources/documents/BHeCCorporatePlan2010-2011.pdf>

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## Context

12. The BHeC utilizes information and statistics on health outcomes and health system expenditure in Bermuda to assess the health system's long-term sustainability. Table 1 presents key statistics on health outcomes and health expenditure that are critical to the future sustainability of Bermuda's health system.

**Table 1.** Key Bermuda Health Facts and Statistics<sup>3</sup>

<b>Life Expectancy at Birth (2009 vs 1950)</b>	79.3 vs. 65.0 years
<b>Median Age of Population (2009)</b>	40.2 years
<b>Percentage of Population Identified as Overweight or Obese (2006)</b>	64%
<b>Percentage of Population Living with Diabetes (2008)</b>	14%
<b>Leading Cause of Death (2007)</b>	Circulatory System Diseases (CSDs) - 47%
<b>Total Health System Expenditure (2008)</b>	BD\$ 496.3 mil
<b>Private Expenditure on Health (2008)</b>	BD\$ 245.0 mil
<b>Per Capita Health Expenditure (2008)</b>	BD\$ 7,730
<b>Annual Growth in Health Expenditure (2000-2008)</b>	8.8%
<b>Percentage of Annual Health Expenditure Financed via Health Insurance (2008)</b>	52.4 %
<b>Forecasted Annual Health Expenditure in 2016 Given Current Rate of Growth</b>	BD\$ 1.04 billion
<b>Percentage of Total GDP Spent on Health System (2008)</b>	8.5%

13. The facts and figures presented in Table 1 have implications for the future sustainability of Bermuda's healthcare system and are, therefore, of importance to the BHeC. Our concerns, presented in this consultation paper, focus on three critical aspects of the current regulatory framework for health insurers. Each is discussed in detail below; in summary they are:
- i. Prudential management of health insurers (in the context of the estimated growth in Bermuda's annual health expenditure by 2016; the fact that private health insurers insure the greatest segment of the population; and the impact of the recent financial crisis on insurance markets).

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<sup>3</sup> Bermuda Health Council (2010). Health System Profile Bermuda 2009: Monitoring and Analyzing Health System Reform. Published by the Bermuda Health Council.

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- ii. Population demographics (in the context of the high incidence of chronic non-communicable diseases, and the need to provide integrated care to manage chronic illnesses in an aging population, more effectively, and at lower cost).
  - iii. The predominance of group insurance and the difficulty for some categories of individuals to obtain affordable coverage (retirees, self-employed business operators, under-employed young adults, those with pre-existing conditions, and the sick).

### ***Prudential Management of Health Insurers***

- 14. As Table 1 indicates, Bermuda spent BD\$496.3 million on healthcare in 2008, or BD\$7,730 per capita. This expenditure represented 8.5% of Bermuda's 2008 per capita nominal GDP of BD\$92,818. The 2008 expenditure level is the result of an 8.8% average annual growth rate in health expenditure since 2000<sup>4</sup>. Assuming that total health expenditure continues to grow at 8.8% per annum the health system will cost the residents of Bermuda approximately BD\$ 1.0 billion annually by 2016.
- 15. Health insurance currently finances 52.4% of all health system expenditure in Bermuda. If we assume that the share of financing will remain constant, health insurers will receive just over BD\$ 500 million per annum in health insurance premiums from insureds by 2016. As the annual cash flow value of health insurance is driven higher by rising health expenditure, so too is the financial (credit) risk, vis-à-vis health insurers, being born by insureds and the wider health system.
- 16. With this in mind, improved prudential regulation of health insurers is essential to ensure that standards for solvency, capital adequacy, liquidity, and asset liability management are compatible with our goals of a transparent, fair, and regulated health finance system powering a sustainable health system. This objective is especially pertinent in light of the events of 2009: the receivership of British American Insurance Company; the withdrawal of ALICO (at the time an AIG subsidiary) from the Bermuda market; and the reporting of reduced profits and large capital draw downs, due to investment portfolio losses, by holding companies that own local health insurers.
- 17. Our consultations with the BMA and MoF served to increase our understanding of the current prudential regulatory regime for health insurers. We especially wanted to understand the level of risk management review that Bermuda's health insurance companies, both as stand-alone companies and as subsidiaries of multi-line insurance corporate groups, are subject to under the Insurance Act 1978.

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<sup>4</sup> Bermuda Health Council (2010). *Op. cit.*

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18. The Insurance Act 1978 (IA) is an omnibus act designed to allow for the prudential regulation of all insurance companies, regardless of ownership structure, size of capitalization, or lines of business underwritten. The Insurance Act 1978 has established regulations that set capital adequacy, solvency, and liquidity standards for local health insurance companies. Having consulted with the BMA on planned changes to those regulations, the BHeC is satisfied that the prudential standards in the Insurance Act 1978 will be strengthened and enhanced by the BMA's move to obtain regulatory equivalency with the European Commission's Solvency II risk capital regime by the end of 2012. Strengthening these prudential regulations will lower the financial risk to policy holders, the health insurance market, the public/taxpayers, shareholders, and the government, of a future insolvency risk.
  19. However, the Insurance Act 1978 does not contain regulations pertaining specifically to the social and public good imperatives of health insurance. Those imperatives are captured in the mandates of the Health Insurance Act 1970 (HIA). Sections 20 through 25 of the Health Insurance Act 1970 created the health insurance system that exists in Bermuda today. As progressive as the legislation was in 1970, the Health Insurance Act 1970 does not contain provisions adequate for the regulation of the dynamic, complex health insurance industry that exists in Bermuda today. Our policy goals and objectives enhance the powers of the Health Insurance Act 1970 to allow it to appropriately regulate health insurers in Bermuda's evolving health, demographic, and economic conditions.
  20. Finally, the Bermuda Health Council Act 2004 accords to the BHeC the function of licensing "health insurers". We will amend both the BHeC Act and the Health Insurance Act to add a full definition of "health insurer" and detail the new annual health insurer licensing requirements that were agreed with the industry in December 2009.

### ***Population Demographics***

21. Life expectancy for Bermuda's population is approaching 80 years of age; in 1950 life expectancy was 65 years of age. The median age of the population is now 40.2 years. The leading causes of death on the island are associated with chronic, non-communicable diseases. Chief among them are circulatory system diseases, which include atherosclerosis, congestive heart failure, hypertension, and peripheral vascular disease, among others. Circulatory system diseases were responsible for 47% of all deaths in 2007. Lifestyle factors such as poor diet, lack of physical activity, smoking, and high levels of alcohol consumption contribute to the incidence of these conditions.
22. Circulatory system diseases, along with cancers, diseases of the respiratory system and other chronic non-communicable diseases are anticipated to drive and intensify health system utilization and expenditure over the next decade.

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The management of chronic diseases requires integrated services from preventive care, to primary care, to hospitalization. This has two implications for Bermuda's health system. First, it challenges the degree to which the standard hospital benefit package can adequately meet the basic healthcare needs of the population. Secondly, it requires a financially strong and well functioning health insurance system that treats all strata of the population fairly and equally.

23. Health insurance provision in Bermuda has been tied to employment since the passage of the Health Insurance Act 1970. Over the ensuing decades, with the island enjoying full employment, employer-provided group health insurance served the island well as the principal means of financing access to health services. However, with a growing population of retired seniors living on fixed pension incomes Bermuda finds itself increasingly unable to depend solely on employment to provide health insurance, and therefore health care, to its residents.<sup>5</sup>
24. An ageing population, with a growing number of seniors living on incomes below the low-income threshold<sup>6</sup>, also means that Bermuda's low income population cohort will grow in size. This situation places the issue of the affordability of health insurance for individuals high on the agenda, as a matter in need of regulatory oversight.
25. The Health Insurance Department (HID) reported that there were 2,772 seniors enrolled in FutureCare (the government-operated and subsidized health insurance plan for seniors) as at May 3<sup>rd</sup>, 2010. Additionally the government is supporting the health insurance needs of 1,428 seniors who are retired civil servants under its Government Employees Health Insurance (GEHI) scheme. Thus the Government of Bermuda is providing health insurance, in one form or another, to 4,200 seniors. According to the Department of Statistics' population estimates there are currently 8,313 persons aged 65 or older in Bermuda.<sup>7</sup> Fifty one percent of our seniors are currently insured via the government, either through its subsidized senior's health plan, or its retiree's health plan.
26. FutureCare provides essential health coverage for seniors at a time when capacity is constrained and private individual coverage for this population can be financially inaccessible. However, the forecasted increase in the senior population over the next decade raises concerns about the long term viability of the plan. FutureCare is designed to cover seniors, the highest risk population, which leaves the healthier, younger, and lower risk individuals out of its pool, presenting a high burden and risk for the plan, and thereby benefiting private plans. Reforms proposed in the consultation paper seek to diversify private in-

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<sup>5</sup> According to the 2000 Census, 95% of the Bermuda population was covered by health insurance. Current estimates put the figure in the in the 90% to 95% range.

<sup>6</sup> Department of Statistics (2008). Low Income Thresholds: A Study of Bermuda Households in Need. Government of Bermuda: Bermuda.

<sup>7</sup> Department of Statistics (2006). Mid-Year Population Projections: July 1, 2000 to July 1, 2030. Department of Statistics. Government of Bermuda: Bermuda.

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surer risk pools to ensure all payers share an equal responsibility in financing healthcare for the population as it ages.

### ***The Need to Expand Coverage for Individuals and Protect Public Finances***

27. The Government of Bermuda's FY 2008 health expenditure was BD\$144.0 million, or 29% of total health system expenditure. Public spending on health increased by 71% between 2000 and 2008. Public health expenditure is the government's largest category of expenditure; it includes the hospitalization subsidies provided by the government and the administration costs of the government-run health insurance plans for seniors and other individual insureds. The ability of the government to expand fiscal spending, including health expenditure, in future years could be constrained by economic conditions and a growing aversion to increased public sector borrowing, both by the public at large and by the global capital markets.
28. The issue of the decreasing affordability of health insurance for individual insureds is a growing problem. As stated earlier, per capita health expenditure in Bermuda was BD\$ 7,730 in 2008. This figure can also be viewed as a proxy for the average annual cost of health insurance. The expenditure represents 7.6% of a BD\$ 100,000 annual income, 15% of a BD\$ 50,000 annual income, and 21% of a BD\$ 36,000 annual income. The Department of Statistics determined BD\$36,605 as the "low income cut-off", akin to a poverty line, with 11% of all households in Bermuda represented in 2008 (and with large numbers of the over-65 population in the cohort).<sup>8</sup> These figures indicate the relatively high financial burden that health insurance represents to Bermuda's low income households that purchase health insurance on an individual basis.
29. FutureCare and the Government Health Insurance Plan (the government-operated health insurance plan for working age adults) are examples of government intervention in the health insurance market to address gaps left by the current health insurance requirements. Future budget constraints will impact on the ability of the government to further accommodate the growing population of individuals in Bermuda who cannot purchase affordable, individual policies through the private insurance market. Included in this population are retirees, self-employed persons, small business operators, under-employed young adults, and persons with pre-existing conditions.
30. The proposed regulatory reforms introduced in this consultation paper are designed to promote equity in coverage by ensuring affordable private insurance policies for the growing number of individual insureds and low income populations. A key goal of the broad policy objectives presented in section 3 of the consultation paper is to promote wider risk sharing amongst health insurers in

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<sup>8</sup> Department of Statistics (2008). Low Income Thresholds: A Study of Bermuda Households in Need. Government of Bermuda: Bermuda.

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the Bermuda market. Achieving this goal will reduce the financial burden of, and risk to, the government.

31. With a majority of Bermuda's population depending on health insurance for access to health care, and 5% to 10% without coverage, the BHeC must exercise stewardship of the health insurance system. By enhancing the regulatory framework for health insurers and health insurance contracts the sustainability of our health system will be safeguarded for the future. The proposed reforms are therefore social and economic imperatives.

### ***Benefits for Health Insurers***

32. The BHeC believes there are several benefits to health insurers from the envisioned reforms. First, making a minimum standard health insurance benefit mandatory for all health insurers to offer for sale, and accessible to the whole population will make the overall pool to be covered by private insurance larger and diminish the risk of adverse selection. Second, the proposed guidelines will create a level playing field for all insurers to allow fairer competition. Third, transparency will ensure risks assumed by individual insurers are more fairly distributed and that 'hidden' risks do not harm the system's sustainability. Finally, transparency is beneficial for all markets as it allows for price discovery and quality comparison, which fosters competition and efficiency amongst participants, and rewards insurers who serve the public interest.

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## III. Overview of Proposed Regulatory Enhancements

### Policy goals and Objectives

33. The founding principles of any health system must reflect the value that health is a fundamental human right<sup>9</sup>. This principle can be identified as a core element underlying the key legislation which established Bermuda's health system: the Public Health Act 1949, the Health Insurance Act 1970, and the Bermuda Hospitals Board Act 1970.
34. Our high level policy goals also reflect this core principle and are aimed at ensuring the sustainability of the system. They are to:
  - i. Protect the Public
  - ii. Promote Equity
  - iii. Promote Cost Efficiency

#### *Protect the Public*

35. **Ensuring the financial solvency of health insurers to protect the public, tax payers and policyholders.** This will be achieved by the establishment of the BMA's risk-based solvency and capital adequacy standards. As a result, a more robust risk management practice standard will be established for all payers. Increased financial reporting requirements that bring transparency to the financial and underwriting performance of health insurers, as well as their ownership structure, will also be established. This goal will be accomplished through amendments to the Insurance Act 1978 that the BMA will introduce to achieve regulatory equivalence with the Solvency II regime to be introduced in 2012. Prudential regulations for Approved Schemes will also be introduced. The time frame for this initiative is in accordance with the BMA's timelines.
36. **Amending the current reporting requirements for the annual re-licensing of Bermuda health insurers.** This is essential for enhancing the oversight role of the BHeC and eliminating information asymmetry between the regulators and the health insurers. This objective, due by March 2011, will be achieved by aligning the health insurer re-licensing period of the BHeC with that of the BMA and by amending the Health Insurance (Licensing of Insurers) Regulations 1971 to require submission of the following information in support of license applications:
  - i. A copy of the most recent statutory return submitted by the applicant to the Bermuda Monetary Authority;
  - ii. A copy of the applicant's most recent audited financial statements;

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<sup>9</sup> General Assembly of the United Nations (1948) Universal Declaration of Human Rights. Article 25(1)

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- iii. A copy of the most recent audited financial statements of the parent or majority owner of the applicant's common share capital;
  - iv. A schedule of the applicant's assets, listed by asset class (example: common stock, preferred shares, government bonds, corporate bonds, asset-backed securities, mortgages, real estate, cash, etc), rating, and by percentage of total investment portfolio;
  - v. Copies of the currently in force versions of the applicant's health insurance policy forms in respect of group policy holders and individual policy holders;
  - vi. Total yearly claims data, including claims for hospitalization, physician, dental, prescription drug, overseas treatment, and other categories of claims as the BHeC may request; and
  - vii. A report of the number of persons covered by a health insurer's policies in Bermuda as at March 31<sup>st</sup> of the most recent fiscal year.
37. **Mandating transparency and fairness in the contractual relationship between health insurers and their policyholders.** This initiative will require that insurers fully disclose all benefits, exclusions, requirements, limits, and costs of a health insurance policy to policy holders and insureds, in plain English, both in print and on their web sites. We seek to implement this initiative by April 2011.
38. **Ensuring that the standard health insurance benefit package provides adequate financial protection for policy holders.** This initiative relates to work the BHeC is undertaking to review and reform the standard hospital benefit (SHB), the schedule of hospitalization benefits that all insurance contracts must contain at a minimum. The goal is to transform it into a more robust, comprehensive "standard health benefits" package that will provide enhanced healthcare coverage beyond hospitalization. The review will also seek to identify mechanisms to ensure equitable reimbursement for providers of SHB services. Work to achieve this objective is underway currently and will be coordinated with the development of the national health strategy by the Ministry of Health. A timeline for this will be established during the current fiscal year.

### ***Promote Equity***

39. **Minimizing adverse selection for insurers and ensuring adequate insurance coverage for insureds.** We will enhance mechanisms to protect health insurers with respect to an enhanced standard health benefit package, such as enhancing system-wide reinsurance cover for high cost claims, or implementing a risk equalization scheme. This enhancement is planned to be implemented by April, 2013. In addition, we are also considering mandating individual enrollment in health insurance plans of persons who are either not members of an employee group or a dependent. Regulatory enhancements to achieve this objective are due April 2012.

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40. The corollary to the enhancements to protect insurers will be regulations that require guaranteed issue and renewal of all health insurance policies and which prohibit discrimination against individuals based on age, sex, race, or pre-existing conditions. New regulations that establish system-wide lifetime coverage limits are also being contemplated. The time frame for implementing the guaranteed issue and renewal, and non-discrimination enhancements is April, 2011. The enhancements to regulate lifetime limits are planned for implementation in April 2012.
  41. **Promoting premium setting policies that create cross subsidies between the healthy and the sick, and between income levels.** We aim to achieve this objective through requirements that the forthcoming enhanced standard health benefits package (described above in 38) be available for sale to the entire population as a stand-alone health plan, and as the base layer of all major medical health plans, and that the standard health benefits package be priced via a community rating methodology. This will require mandating that the standard health benefit package be sold to everyone at the same price, regardless whether they are covered under an individual or group health policy. In addition, we will investigate mechanisms to enable proportional premium contributions for the package based on a fixed percentage of an insured's salary. Developments in this regard are underway and a timeline will be established within the next fiscal year.

### ***Promote Cost Efficiency***

42. **Ensuring accurate and prompt reimbursement of providers.** This reform was commenced recently as the BHeC introduced a standardized health claims form that will eventually be mandated for use system wide. Also planned are mandates fixing 30 days (as a starting point) as the maximum allowable time frame for the reimbursement of a "clean" and complete claim from the day received. Achieving a 15 day reimbursement standard by 2012 is the ultimate objective. Time frame: April 2011.
43. **Encouraging increased adoption of robust information technology systems by the health insurance industry and providers to execute and record health system transactions and settlements.** The objective is to move the health system toward a fully electronic claims submission, processing, and reimbursement system. International evidence has demonstrated that shrinking the footprint of the administrative costs of the health system, especially the cost of record keeping, makes health systems less expensive and more efficient. Progress toward this objective will be benchmarked. This policy will be developed in 2010 with legislation planned for introduction in 2011.

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## Rationale for the Proposed Reforms

44. Protecting the public by ensuring higher standards for solvency and capital adequacy, and by establishing financial reporting requirements that promote financial and underwriting transparency, mitigates risk for the insured population, employers, taxpayers, private insurers, and the government. These initiatives will also act to reduce moral hazard and information asymmetry between the insurers and those they cover. The BHeC seeks to enhance the accountability of both private and public health insurers.
45. An empowered regulator, transparency of health insurance financial condition, explicit policy pricing, and easy to understand policy terms and conditions are aimed at ensuring our health insurance system works in the public interest. These enhancements will also allow for price discovery and service quality comparison by consumers, and promote real competition (via operational efficiency, not solely on price) by health insurers.
46. Ensuring health insurance packages provide adequate financial protection for insureds is essential to the sustainability of the health system. The redesigned SHB Package will contain a specified minimum package of health benefits that all health insurance policies must offer without exclusions for preconditions or reference to a person's age. These changes aim to enhance access to basic coverage and to reduce overall costs by improving access to primary care which, in turn, can decrease the need for unnecessary hospitalizations.
47. Promoting equity involves ensuring access to health care by all income strata of the population, and minimizing risk skimming and adverse selection, which distort health insurance markets. In Bermuda the self-employed, retired persons and the unemployed are most likely to be uninsured. Extending the ability of individuals to purchase coverage through system-wide, community rated plans will make health coverage more affordable to the most vulnerable populations. In addition, mandating that all individuals purchase coverage will increase the size of the risk pool and protect insurers against adverse selection.
48. Requiring the standard health benefit package to be community rated promotes cross subsidies and economic burden sharing between the young and the old, the healthy and the sick. When combined with a system wide reinsurance or risk equalization scheme it also promotes the development of larger and more sustainable risk pools.
49. Finally, the forecasted increase in health system utilization, expenditure, and costs, driven by Bermuda's demographics (see 14) make the assurance of a sound health insurance system both a social and economic imperative. Bermuda must have a financially sound, fair, and cost efficient health insurance system if we are to meet the health care needs of the population over the next decade.

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## IV. Alignment with BHeC Authorities and Strategic Objectives

50. The Bermuda Health Council is established as the licensor of health insurers in Bermuda by **the Health Insurance Act 1970**. The Act states in Part V, section 40, that “The Minister may, acting on the recommendations of the [Bermuda Health] Council, make regulations for the purpose of carrying this Act into effect and, without prejudice to the generality of the forgoing, regulations may...
- (f) Provide for the regulation and control of licensed insurers;
  - (g) Require licensed insurers and employers to submit such reports and records relating to insured persons as the minister shall determine...”
51. **The Bermuda Health Council Act 2004**, Part II, Section 5(g), accords to the BHeC the function of licensing health insurers. As discussed earlier, the proposed enhancements to current health insurance legislation and regulations put forward in this consultation paper have been reviewed and endorsed by the Ministry of Health. The Ministry’s endorsement was given in the public interest, in accordance with the Bermuda Health Council Act 2004, Part II, section 7.
52. The **BHeC Strategic Plan 2009-2012**<sup>10</sup> identifies four strategic goals: quality, equity, efficacy, and accountability. Each strategic goal has objectives. The strategic goals of quality and equity have objectives that are most pertinent to health insurance.
53. The objectives for quality commit the BHeC to collaborate with the MoH to enhance the regulatory framework for health insurers, and to develop and implement an impartial and effective system to oversee and monitor compliance with established regulations.
54. The objectives for equity commit the BHeC to enhance processes to assure equitable access to essential healthcare services. The proposed enhancements to the regulatory framework for health insurers seek to assure financial access to essential healthcare for the whole population.
55. Finally, the **BHeC Corporate Plan 2010-2011**<sup>11</sup> identifies the 2010 – 2011 fiscal year as the timeframe for significant developments, in collaboration with the MoH, in the strategic objectives regarding quality and equity.

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<sup>10</sup> Bermuda Health Council. (2009). Quality and Sustainability in Healthcare: Bermuda Health Council, Strategic Plan 2009-2012. Published by the Bermuda Health Council.

<sup>11</sup> Bermuda Health Council. (2009). Bermuda Health Council, Corporate Plan 2010-2011. Published by the Bermuda Health Council.

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## V. Cost Benefit Analysis

56. A fair and open consultative process should involve presentation and explanation of all proposed regulatory changes by the regulator. The presentation should also include the rationale for the desired changes, and an estimate of the costs and benefits of implementing the new regulations to those potentially affected by the proposals. This section identifies the key costs that Health insurers may incur should the proposed changes be implemented. Likewise, benefits to Health insurers and to the health system and insureds are also identified. We are focusing on high level costs and benefits. We welcome feedback on this aspect of the consultation paper and invite you to do so in section 6 of the paper.
57. **Costs** – Health insurers are likely to incur changes to the costs of the following inputs to operating a health insurance business in Bermuda should the regulatory proposals outlined in this consultation paper be implemented. The direction, degree, and severity of any cost change will vary from firm to firm, depending on the size of the company/group and the current level of sophistication of its operations infrastructure:
- i. Higher annual license and approval fees;
  - ii. Higher capital costs, and higher costs for financial risk management talent/services, associated with meeting the BMA's Solvency II equivalent risk-weighted capital regime;
  - iii. Higher costs for meeting compliance requirements of the new financial and health insurance mandates, including legal consultants and staff training;
  - iv. Possibly higher cost for IT systems development, programming and consultancy. This should be offset by lower overall administrative costs over the medium and long term.
58. **Benefits** – Health insurers will benefit most from the sustainability and efficiency that the proposed reforms will promote in their business models. This fundamental shift should, over the long term, increase the enterprise value of the companies that adapt. The key high level benefits of the proposed reforms are:
- i. Lower underwriting and actuarial costs due to the simplified rating systems and reduced underwriting resources required for the new expanded standard health benefits layer of all health insurance packages.
  - ii. Broad, shared, risk pooling will reduce the risk to individual insurers from adverse selection, which in turn eliminates the need for risk rating by health insurers. This fundamental change in the business model should result in improved public perception of health insurers and increased goodwill.

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- iii. Transparency of the financial condition of insurers, and of the costs, benefits, and terms and conditions of health insurance policies will benefit share holders and policy holders.
  - iv. Efficient Competition. Many of the proposed reforms will result in health insurers competing via increased administrative efficiency, improved service quality, and through the building of more efficient economies of scale.
  - v. Financial security for tax payers and the government, both from the lowered risk of insolvency, and from more equitable access to the health system for all insureds, especially retirees, those who fall sick, and those with pre-existing conditions, which promotes sustainability.

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## VI. Next Steps – Providing Feedback to this Consultation Paper

59. The Bermuda Health Council welcomes and invites comments and feedback from health insurers, employers, health care professionals, and the public on the information presented in this consultation paper. Comments and feedback will be accepted in writing only and should reach us by 30<sup>th</sup> August 2010.
60. You can submit your comments and feedback via e-mail or in writing to:
- Dane Commissiong  
Director of Health System Regulation  
The Bermuda Health Council  
Sterling House, 3<sup>rd</sup> Floor  
Hamilton  
P.O. Box HM3381 HMPX  
[dkcommissiong@bhec.bm](mailto:dkcommissiong@bhec.bm)
61. Information from individual health insurers quantifying the potential costs of the regulatory proposals to their firms is especially welcomed. All information submissions will be handled with strict confidentiality.
62. The BHeC and the BMA have established a joint working group to ensure coordination in the enhancement of the regulatory regime for Bermuda's health insurers. The working group is composed of senior BHeC executives and our counterparts from the BMA's Insurance Licensing and Authorizations and Complex Institutions Departments.
63. The Annex to this consultation paper contains our proposed regulatory enhancements for health insurance in summarized table format.

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## List of Acronyms

<b>BHB</b>	Bermuda Hospital Board
<b>BHeC</b>	Bermuda Health Council
<b>BMA</b>	Bermuda Monetary Authority
<b>GDP</b>	Gross Domestic Product
<b>GEHI</b>	Government Employee Health Insurance
<b>HIAB</b>	Health Insurance Association of Bermuda
<b>HID</b>	Health Insurance Department
<b>HIP</b>	Health Insurance Plan
<b>MoF</b>	Ministry of Finance
<b>MoH</b>	Ministry of Health
<b>SHB</b>	Standard Hospital Benefit

## Annex: Policy objectives recommended to enhance the regulation of health insurers

Policy Objective	Policy instrument	Explanation	Rationale	Operationalization	Implementation
<b>Policy Goal 1: Protect the Public</b>					
1.1 Ensure financial solvency of insurers	1. Establish risk-based solvency and minimum capital standards; and set risk management parameters and standards for all payers.	Imposes financial risk management standards that lower financial failure risk and the need for Govt. bailouts in the future.	Risk mitigation for the insured population, employers, tax payers and the Government. Reduce moral hazard and information asymmetry. Essential to enhance accountability of private and public payers, including MRF, HIF & GEHI. This will enable supervision and monitoring of the financial solvency of all health insurers & approved schemes.	A risk-based regulatory capital regime with capital adequacy driven by a risk assessment model (asset/liability/operations). Uniform contingent capital requirements for approved employer health schemes. Yearly joint filing of audited statutory returns to BMA & BHeC.	By the BMA in accordance with their process and timelines for implementation of Solvency II framework. BHeC to provide input via the joint working group.
	2. Establish financial reporting requirements that ensure financial and underwriting transparency.	Eliminates information asymmetry between the regulators and health insurers. Requires health insurers to separate and explain the operations results of the health insurance operating entity separately from any parent and or sister companies.	An empowered regulator and mandated balance sheet transparency promotes sound financial management behavior, and promotes sustainability via the reduction of institutional moral hazard. Will enable creation of long-term data sets for system analysis.	Enhanced version of current BMA statutory return, with addition of an asset class schedule, and 5yrs of premium, claims & expense data to be mandated. Amendments to BHeC and H.I. Acts adding reporting requirements for financial condition and underwriting performance by health insurers, & approved employer health schemes.	By the BMA in accordance with their process with their timelines. With input from the joint working group. Dual reporting proposed.
1.2 Mandate transparency and fairness in the contractual relationship between the health insurer and insureds	3. Establish disclosure requirements for policy terms and conditions, benefits and costs.	Mandate disclosure requirements for policies and costs requiring that their content is understandable to consumers in plain English and available to insureds in print and on web site.	Promotes transparency, policy comparison, and price and quality discovery by the public. Ensure the public are informed, independently of employers, in order to make educated decisions.	HIA 1970 amendment requiring yearly submission for review by BHeC of health insurance policy form (SHB & Major Medical) by licensed insurers and mandating availability on web sites.	April 2011
1.3 Ensure that health insurance package provides adequate financial protection.	4. Expand the standard benefit package that all insurers must offer, with a premium established based on community rating model.	SHB currently provides for this, but will be improved. Constitutes a government mandated social good to be offered to all citizens on a non-discriminatory basis. Mechanisms to ensure fair and equitable reimbursement of providers to be included.	Ensures a minimum package of benefits for all insureds that includes preventative primary care and hospitalization, and supports better, more cost effective management of chronic diseases. Inconsistencies in reimbursement of providers for non-hospital standard benefits need to be resolved.	Expand the minimum community rated standard benefit package that all insurers must offer to the public to broaden current limitation to hospitalization. Annual re-evaluation of premium and benefits by BHeC.	In place currently but enhancements due April 2012.

Policy Objective	Policy instrument	Explanation	Rationale	Operationalization	Implementation
<b>Policy Goal 2: Promote Equity</b>					
2.1 Minimize adverse selection and ensure adequate insurance coverage for all Bermudans	5. Enhance mechanisms to protect insurers such as system-wide reinsurance and risk-equalization schemes.	Reinsurance and risk-equalization measures (MRF) and hospitalization subsidies provide system-wide layer of protection for individual insurers from high severity claims, and distribute risk across the system.	Current position of MRF represents a potential moral hazard and requires strengthening. Current subsidies provide risks equalization for key high risk groups.	Oversight arrangements for the MRF need to be enhanced to ensure effectiveness, transparency and accountability.	In place but needs enhancing. April 2013.
	6. Mandate individual enrollment if not in group or dependent.	Requiring all residents to have health insurance cover reduces the potential for adverse selection for health insurers. It also ensures universal coverage for the people of Bermuda.	Self-employed, retired, and unemployed populations are the most likely to be uninsured. Mandating individual coverage reduces the risk to tax payers of unnecessary emergency room use and from uncompensated care. Promotes equity.	Develop and establish mechanisms to mandate individual enrollment if not in a group or a dependent.	April 2012
	7. Require guaranteed issue and renewal of health policies; along with pricing guidelines make premiums more affordable for sicker individuals.	Require insurers to provide the standard health benefit to everyone, and prevent them from denying coverage or charging higher premiums based on age, gender or pre-existing conditions.	Currently insurers can effectively choose whether to provide SHB cover and to whom, which led to seniors being adversely selected for much higher premiums in 2009. An accurately priced standard premium (SP) will ensure this requirement is fair to insurers.	Amendment to HIA 1970 & HRA to prohibit health insurers from denying coverage to any individual for pre-existing or subsequently diagnosed medical conditions. Amend HIA to mandate insurers to provide SHB to everyone at a set price.	April 2011
	8. Regulate lifetime limits on coverage.	Lifetime limits are provisions in health insurance plans that limit the total dollar amount in benefits that the insurance plan will pay over the lifetime of an enrollee. The limit can be reached with a catastrophic medical condition, which disadvantages the sickest.	In the US 55% of employer plans have lifetime limits, most between \$1m & \$2m. Cost of increasing to \$5m has been estimated would cost 1% (\$3 monthly).	<i>Proposals to operationalize this policy instrument need to be developed in line with #6, provision of system-wide reinsurance and risk-equalization.</i>	April 2013
2.2 Promote premium setting policies that promote cross-subsidies between healthy and sick and between income levels.	9. Require community rating of the standard benefits package to promote cross-subsidies between healthy and sick.	Community rating requires health insurers to offer policies at the same price to all persons without medical underwriting, regardless of their health status. Currently in Bermuda the "Standard Premium" is community rated.	It promotes burden sharing between young and old, healthy and sick. Promotes affordability of coverage for the elderly and the sick.	Set Standard Premium in line with actuarial recommendations annually and publish report. As the Standard Benefits are expanded there'll be greater equalization.	In place currently; continued commitment.

Policy Objective	Policy instrument	Explanation	Rationale	Operationalization	Implementation
	10. Consider mechanisms to make premiums be set based on ability to pay.	Provides for cross-subsidy in healthcare financing between high and low income individuals to ensure affordability of coverage for broad basic package.	Currently 20% of poor households' income is spent on healthcare, compared to 3% in wealthy households. Proportionality helps spread the financing risk as health care expenditure rises relative to incomes.	<i>Proposals to operationalize this policy instrument will be developed by BHeC over the coming year.</i>	April 2013
<b>Policy Goal 3: Promote Cost-Efficiency</b>					
3.1 Ensure accurate and prompt reimbursement of providers.	11. Standardize health insurance claims forms.	All health providers eligible for H.I. reimbursement to adopt use of the BHeC-adapted HICF claims form.	HICF form is based on the MED-ICARE claims form designed by the US DoH and used across the U.S. and in software used by many Bermuda providers at present.	Standardization of use of the HICF form will allow for benchmarking the health insurance industry progress toward a fully electronic online health insurance payments and approvals system.	Timeframe to be determined
	12. Mandate reimbursement to providers in 30 days max ( <i>via electronic claims processing</i> ).	Encourage health insurance industry and providers to use more robust IT Systems to execute and record transactions and settlements in order to make reimbursement and record keeping more cost efficient.	System efficiency could be improved through enhanced use of IT. Electronic claims processing is a key efficiency needed. Goal: get to a 15 day standard by 2012.	HIA 1970 to mandate payments by health insurers to providers within 30 days of receipt of claims. Benchmark progression to a fully electronic claims processing and payments system; providers will have to be similarly legislated.	April 2010 policy; April 2011 legislation
3.2 Encourage adoption of robust information technology systems to move towards 100% electronic claims processing.	13. Move the health system to fully electronic claims submission and processing.	This will shrink the administrative footprint of the health system and make the system more efficient and less expensive over the long run.	There are many delays and errors in claims processing which are costly for both the insurers and the providers. Electronic claims submission and processing is now the standard in most countries and will reduce errors and increase timeliness of provider payments.	Policy will be developed in 2010 with Legislation being introduced in 2011.	Policy in 2010. Legislation: 2011.