Annex – 1

NHI Concept- Background for Actuarial Study

16 November 2020

The policy thrust implicit in the proposed national health insurance system is that, through pre-payment and pooling citizens can receive expanded access to health services through limiting and in some cases eliminating of out of pocket expenditures for a myriad of health services. The intent is to boost the ability of the public to access needed health interventions primarily through expanding the ability to access private health facilities and receive laboratory and diagnostic care that is currently not covered by the State. The State believes that over the medium to long term such incentivizing preventative measures and facilitating early diagnostics could lower health care cost and minimize the incidence of non-communicable diseases. The State believes that it can achieve these goals by legally mandating the working age population to obtain an insurance package that, at a minimum[1], covers a basic level of health interventions. The results of a 2016 survey[2] show that 18.0% of the working age population have health insurance. Where the working age citizen in poor, unemployed or otherwise deemed vulnerable, the State will pay for such premiums on their behalf while the non-poor are expected to purchase such policies in collaboration with their employer. The State estimates that there are some 97,000 to 100,000 working age adults and that some 34,000 of them would need State assistance in procuring insurance. The population of Saint Lucia is approximately 170,000. This would mean than some 70,000 persons will be dependents and therefore any financing modality for health expansion would need to factor in how access, of insured benefits by dependents will be paid for.

An insurance mechanism is expected to significantly enhance the level of cost recovery in health expenditures and thereby potentially serve as a financing mechanism for health expansion. Currently, a large percentage of individuals who access the health facilities do not pay for care and in the instance where they do, the charges are at subsidized rates (often below true cost). This has the effect of contributing to a depreciation of both the capital stock and the quality/ quantum of health interventions. The State is desirous of exploring what the quantum of cost recovery would be, should a myriad of services currently provided by the State be reimbursed through insurance. This cost recovery is expected to be used to partially cover the cost of the premiums which the State will incur to provide the poor and vulnerable with insurance. Based on the aforementioned an actuarial review can assist in determining;

- The extent to which premiums paid by the working population will sufficiently allow for full coverage of the essential health benefits package for both **the working and non-working[3] age** populations.
- What level of cost recovery can the government expect?
- What is the impact on the typically employee and employer?

[1] Non-poor who currently have insurance can keep their existing coverage to the extent that that policy covers the essential services mandated by the State

[2] 2016 Survey of Living Conditions and Household Budgets - CSO

[3] Particularly for those persons over 65 years

- What level of premiums are sustainable over the next 10 to 20 years?
- What is the likely cost of the proposed essential health benefits package over the next 10 to 20 years?
- What is the true cost of all health services that are not a part of the proposed essential health benefits package?

As a follow up the State would also appreciate an assessment by the actuary of which diseases would be most and least costly (re the impact on premiums) and also would in the long run benefit from the most from increased preventative care. A comparison of a baseline health expenditures (i.e. should access to preventative care remain as is) to varying degrees of increased access to preventative care would be appreciated.

The subvention to the Ministry of Health in fiscal year 2019/20 was $132.0m with those funds mainly covering fixed operations, a limited capital budget and de facto recurrent cost (service delivery). The State does not intend to reduce this level of subvention but increase its efficiency by boosting cost recovery and using the resulting funds to enhance quality and cover insurance premiums for the vulnerable.

We recognize that the aforementioned policy objectives would create an insured basket of services and an uninsured basket. Some services within the insured basket may require the citizen to access services internationally (if referred by their doctor). The potential and impact of this [external care], based on the insured services and the ensuing cost are areas the State would also appreciate some comment by the actuary.

To date formal discussions with the insurance industry has not begun. The NHI Committee has shared a draft essential health benefits package with the medical community and other stakeholders. We believe an actuarial review can assist in appropriately costing such a package under varying take up and incidence rates. Insurance companies are expected to be engaged with a view to achieve several outcomes. One of those outcomes would be to see whether a syndicate or individual company would wish to provide an insurance policy which the State would purchase (whole) for the poor, vulnerable and unemployed. In addition to that policy, which would be purchased by the State, insurance companies are expected to tailor/refine their products to two other cohorts namely their existing customers and non-poor uninsured. With respect to existing clients the expectations are that current insurance policies by design, should, cover the majority of basic interventions which the State is proposing. Consequently existing policy pricing should either remain as is or decline slightly. The non-poor uninsured would now have a choice between purchasing a conventional insurance policy one that covers a myriad of services further to a basic package or just a basic package. This later choice would mean that insurance providers would now need to create a market for a basic package for the non-poor and employed. Further to these assumptions, it would be instructive to understand what the split would be between the public and private sector re utilization of the essential package.

We also would require that the actuary assess how demographic and other changes could impact the feasibility of the aforementioned proposal. Some of those other changes of interest include the extent to which shifts within our labour markets e.g. becoming less tourism reliant, declines or changes in wage earnings and or a growth in unemployment could impact the feasibility of the initiative. These are particularly poignant points given the tightening fiscal space available to the State on account of COVID-19.

The actuary would therefore need to collate and utilize the following datasets (see below) to advise on how socioeconomic change can affect sustainability.

- Employment information including industry, average salary, and demographics (e.g. age, gender),
- Incidence and severity of hurricanes, tropical storms and other disasters,
- Definition of non-communicable diseases via ICD-10 codes (if applicable),
- Provider fee schedules,
- List of services that are sent to centers of excellence or outside of the country based on complexity,
- Claims data, enrollment data, and census data which includes members potentially not in the claims data.

There are 6 key actions necessary to successfully move forward with NHI and these include;

i. A finalization and definition of the essential health benefits package
ii. Costing of the essential health benefits package
iii. Undertaking of actuarial analysis
iv. Approval of health financing policy
v. Implementing regulatory environment
vi. Reorganization of the Ministry of Health

For greater clarity in designing the actuarial study we have created the FAQ below.

END

Appendix 1: FAQ.

1. **Who will pay the fee?**
    a. Conceptually the fee is to be paid by all employed citizens and residents of and in Saint Lucia. The State has indicated that it would make payments for all unemployed citizens and a fraction of those citizens who are employed i.e. the poor and vulnerable. Dependents i.e. those below and above the working age will be crossed subsidized by the aforementioned cohort.
    b. It is proposed that the fee be paid by employees and employers in equal measure, except in the case where the State is making 100% of the payment i.e. for the unemployed and vulnerable.
2. **What would the fee be?**
    a. Cabinet has advised that fixed fee levies should be explored.
    b. The committee wishes to put forward that any fee/levy should be cognizant of the ability of both the firm and employee to pay and the revenue target necessary to finance the basket of services to be provided.
3. **Who would receive the fee contributions?**
    a. Under the revised approach the insurance company would receive said funds. In the case of the government funded program this would be a bulk payment. All related subtask should feature in the "*Design Development and Implementation of the Health Financing Strategy for the Department of Health and Wellness of Saint Lucia*" consultancy.

4. **What legal mandate exist to give effect to this fee?**
    a. The proposal will require considerable amendments to give the State the ability to levy the fee and also speak to the operational aspects of administering the fee.

5. **How will the fee be collected?**
    a. As mentioned above it may be best to have the fee collected in a manner similar to how NIC and PAYE deductions are remitted. The employer deducts from the employee, matches the contribution and then remits* to the administrator/insurance company on a monthly basis. *Administrative issues need to be discussed.
6. **How would claims be made against the fee?**
    a. This is tied to questions 3, 11 and 12. There is need for an MIS system to facilitate the relationships between vendors, patients and the citizenry. This registration system will in turn require a standard/criteria that a vendor must adhere to in order to be eligible for registration. There is also the need for an explicit list of services and a payout per service. This requires a series of meetings with the SLMDA, Medical Council and Ministry of Health.
7. **What would be the impact of the fee on the typical worker and firm?**
    a. From work done to date fees between $50-$165 would be tantamount to 2-6% of the average wage.
8. **What services would be covered by the fee?**
    a. In the main the fee is to cover all incremental extensions of health services.
9. **How will the administrator manage the program?**
    a. Ideally, we want the administrator to build four competencies namely;
        i. Registration of vendors
        ii. Fund management, accounting and reporting processes
        iii. Payment of vendors
        iv. Verification and auditing of claims
    b. Building these competencies will come at a cost and it is important that these are factored into the equation
10. **Which vendors can participate?**
    a. From discussions to date the ideal is to have the administrator deal only with vendors re making and processing of claims i.e. doctors, clinics etc. All licensed physicians and public institutions will need to undergo a registration process.
11. **How will vendors be reimbursed?**
    a. From discussions to date the ideal is to have vendors paid every 21-30 days. This would mean that vendors will have a receivable on their books during this time period. The payment modality should be direct transfers from the administrator.
12. **How will an individual access the additional services?**
    a. How vendors treat their clients is key. There are two options;
        i. Status quo
        ii. New system:

1. Registered: a client shows proof of being enrolled in the program. That proof should either be an ID or that the portal available to the vendor should indicate based on NIC number etc whether the client is duly registered. Upon certification of proof the vendor extends the service to the client, the client may either pay a co-pay or not out of pocket.
2. Non-registered: if a client is non registered particularly at a public institution that client's details should be taken and this should be channeled to the administrator. That administrator should either pass this information to the government for enrollment in that program or to their employer.