HEALTH COUNCIL
BERMUDA

ADVANCE REVIEW AND APPROVAL FRAMEWORK FOR MATERIAL CHANGES IN BERMUDA'S HEALTHCARE SYSTEM

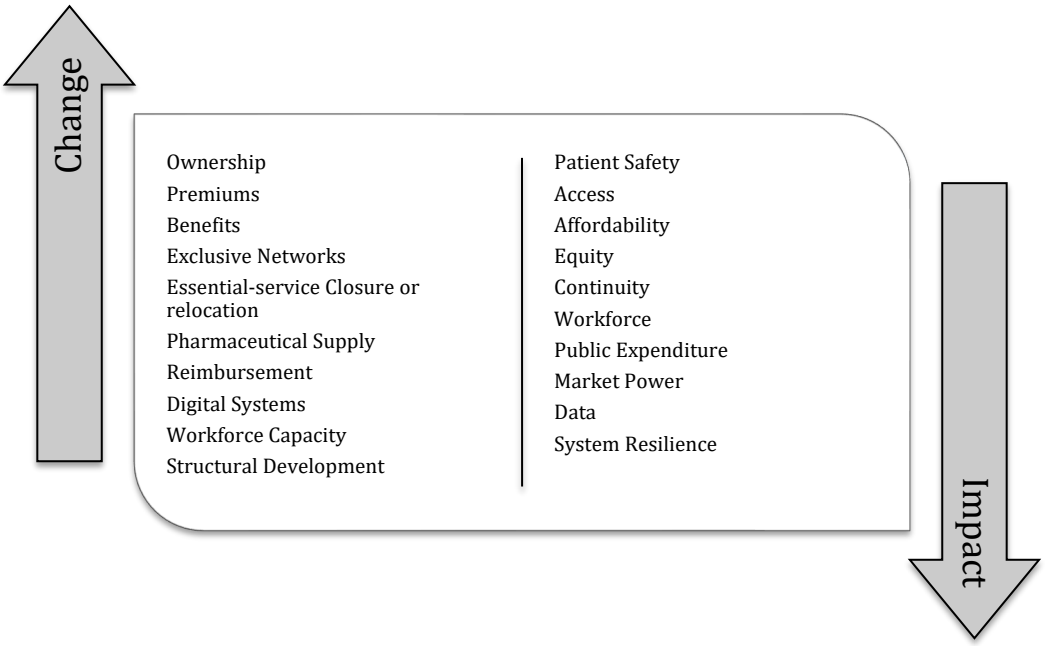
POLICY AND IMPLEMENTATION FRAMEWORK

Contents

Executive summary

Cabinet has approved the Ministry of Health moving to the next phase of an Advance Review and Approval Framework for material changes in Bermuda's healthcare system. The approved direction is to consult affected stakeholders, amend the Bermuda Health Council Act 2004, and prescribe detailed thresholds, procedures and exemptions in regulations. The Cabinet paper identifies the central gap: major changes can presently be announced or implemented before Government has a lawful opportunity to understand their system-wide effects.

This paper converts that approval into a proposed operating model. It is deliberately broader than merger control. A material healthcare change may involve ownership, premiums, benefits, exclusive networks, essential-service closure or relocation, pharmaceutical supply, reimbursement, digital systems, workforce capacity or another structural development. The review must therefore examine patient safety, access, affordability, equity, continuity, workforce, public expenditure, market power, data and system resilience together.



The most urgent design issue is the boundary with the proposed Competition Act 2026. The current Home Affairs consultation proposes a Competition and Regulatory Authority (CRA) with a Healthcare Competition Unit, merger approval in health and pharmaceuticals, a 40 per cent market-share trigger, and the Bermuda Health Council as a consultation partner rather than the lead authority. If both frameworks proceed unchanged, the same healthcare transaction could require two statutory filings, two tests and two final decisions. That conflict should be resolved in primary legislation, not left only to a memorandum of understanding.

Recommended settlement of the overlap

The health framework should be the permanent sector-specific approval regime for material healthcare system changes. A single notice should be filed with the Health Council. The CRA should provide a mandatory competition opinion where relevant, and the Bermuda Monetary Authority should retain its prudential functions. The Minister of Health should make the final health-sector public-interest decision. The Competition Act should expressly prevent duplicate ex ante merger approval in healthcare, while preserving the CRA's powers over cartels, abuse of dominance, market studies and other anti-competitive conduct.

Recommended decisions at this stage

- Confirm the Bermuda Health Council as the single notification and assessment authority for all material healthcare system changes.
- Confirm the Minister of Health as the final health-sector decision-maker, with power to approve, condition, modify, delay or refuse a proposal.
- Adopt a permanent health-sector primacy model, not merely an interim arrangement pending competition law.
- Direct the Ministry of Health, Ministry of Home Affairs and Attorney-General's Chambers to reconcile the two proposed statutes before either Bill is finalised.
- Submit a formal Ministry of Health response to the Competition Act consultation before it closes on 15 September 2026, requesting a health-sector carve-out from duplicate merger approval and a statutory referral mechanism to the CRA.
- Approve the proposed three-level threshold model in this paper as the consultation baseline: administrative filing, screening review and full review.
- Approve a standard 90-day advance-notice rule, with 120 days for presumptively complex changes and a lawful expedited route for urgent safety, supply or financial-distress cases.
- Apply the framework to both public and private entities, with an alternative decision arrangement where the Ministry or Health Council is itself the proponent.
- Authorise an interim voluntary notification protocol while legislation is being developed, without representing that final approval powers already exist.
- Establish a cross-government implementation steering group and a small, ring-fenced Material Change Review Unit within the Health Council.
- Require public summaries, proportionate consultation, published reasons and post-implementation monitoring for significant decisions.
- Place adjustable thresholds and procedures in regulations, while keeping the duty to notify, standstill, review power, Ministerial decision powers, confidentiality, enforcement and appeal architecture in the Act.

Proposed operating model at a glance

Stage	Lead	Core output	Target time
Pre-filing	Health Council	Confidential scope discussion and non-binding indication of likely filing level.	Optional; usually within 10 business days
Notification and completeness	Proponent / Health Council	Formal notice, supporting evidence and confirmation that the filing is complete.	Notice 90-120 days before implementation; completeness within 10 business days
Screening review	Health Council	Clearance, standard safeguards, or decision to open a full review.	20 business days after completeness
Full review	Health Council with specialist referrals	Public-interest assessment and recommendation to the Minister.	60 business days; one 30-day extension for exceptional complexity
Decision	Minister of Health	Approval, conditional approval, required modification, delay or refusal.	10 business days after recommendation
Monitoring	Health Council	Compliance reports, outcome measurement and enforcement where necessary.	6, 12 and 24 months; longer for major transactions

1. Cabinet mandate and purpose

Cabinet approved the Ministry proceeding with targeted consultation and legislative development for a framework that requires advance notice and review of material healthcare system changes. The approved direction is to create a new Part in the Bermuda Health Council Act 2004, supported by regulations that can be adjusted as the market and health system evolve.

The purpose of this policy paper is to define what should happen next: the policy boundaries, threshold design, review procedures, institutional relationships, evidence requirements, decision standard, enforcement model, consultation programme and implementation timetable required to translate Cabinet's approval into an operational regime.

1.1 Outcomes the framework must deliver

- Earlier visibility of major structural, financing and service-delivery changes.
- Independent assessment before consequences become difficult to reverse.
- A lawful standstill preventing implementation before review is completed.
- A whole-system test rather than a narrow commercial or competition test.
- Clear, predictable timelines for businesses, providers and public bodies.
- Meaningful protection for patients without obstructing responsible innovation.
- One coordinated government process, avoiding duplicate filings and conflicting decisions.
- Transparent reasons, enforceable conditions and measurable post-implementation accountability.

2. Policy problem and case for action

Bermuda's healthcare system is small, concentrated and highly interdependent. A single decision by an insurer, provider, supplier or public body can alter access, patient flows, workforce demand, prices, public expenditure and the viability of other services. The current statutory framework regulates particular institutions and activities, but it does not provide a general duty to notify Government before a material health-system change is implemented.

Recent pharmacy and oncology workstreams illustrate the underlying governance problem without predetermining the outcomes of those stakeholder processes. In both cases, a change or service pressure that appeared to concern one organisation or part of the market required a wider assessment of access, clinical dependencies, financing, patient burden, workforce, data, provider viability and system resilience. The policy lesson is that system implications should be considered prospectively and consistently, rather than only after controversy or disruption.

2.1 Why ordinary competition law is not sufficient

Competition is an important part of the review, but it is not the governing test for healthcare. A proposal may improve competition and still create unacceptable safety, continuity or workforce risk. Conversely, a concentrated arrangement may be necessary to sustain an essential service in a population of Bermuda's size, but should be approved only with safeguards on access, pricing, quality and accountability.

Competition-law question	Health-system question
Would the change substantially lessen competition or involve abusive conduct?	Will the change improve or harm patient safety, access, affordability, equity, continuity, workforce resilience and sustainability?
What is the relevant market and market share?	What essential services, populations, pathways and public-financing obligations are affected?

Are there efficiencies that offset competitive harm?	Are benefits real, measurable and achievable without shifting risk or costs to patients, charities or Government?
Can competition remedies address the concern?	What clinical, operational, benefit, pricing, workforce, data or continuity conditions are necessary?

2.2 Risks of leaving the gap unresolved

- Patients and providers learn about significant changes after commercial commitments have already been made.
- Government is placed in a reactive posture and may lack authority to pause implementation.
- Service, workforce and public-financing consequences are fragmented across agencies.
- Commercial parties face uncertainty because no single process defines what information or safeguards are required.
- Parallel health and competition laws may produce duplicate review, inconsistent conditions and litigation risk.
- Staged or serial transactions may cumulatively reshape the system while each individual step remains below a narrow threshold.

3. Objectives and design principles

Principle	Meaning for the framework
People first	The interests, safety and reasonable access needs of Bermuda residents are the primary consideration.
Proportionate regulation	Routine operational decisions should not be delayed; scrutiny should increase with the scale and risk of the proposed change.
Early intervention	Review should occur while options remain open and before contracts, investments or patient pathways become difficult to unwind.
Whole-system evidence	Assessment should include clinical, economic, actuarial, workforce, operational, equity, data and competition evidence.
One front door	A proponent should make one health-sector filing and receive one coordinated timetable and final health-sector decision.
Regulatory neutrality	The same principles should apply to private, charitable and public actors, with conflict safeguards where Government is the proponent.
Transparency with confidentiality	The public should understand what is proposed and why a decision was made, while legitimate commercial information and personal health information remain protected.
Timeliness and certainty	Deadlines should be statutory or regulatory, tolling should be controlled, and the proponent should know the status of the review.
No avoidance by fragmentation	Linked steps, affiliates and serial transactions should be assessed together.
Accountability after approval	Approval is not the end of oversight; significant promises and safeguards should be monitored.

4. Scope, entities and definitions

4.1 Prescribed entities

The framework should apply to any person or organisation that proposes, controls, finances or implements a material change affecting the delivery, financing, access, supply or organisation of healthcare in Bermuda. The statutory definition should be broad enough to include indirect control and new business forms, while regulations can specify classes and exemptions.

- Licensed health insurers and approved schemes, including parent companies and controlling affiliates.
- Licensed health service providers, provider groups, hospitals, clinics, laboratories, imaging providers, care homes, home-care organisations and other prescribed services.
- Pharmacies, pharmaceutical importers, wholesalers, distributors, specialty medicine managers and pharmacy benefit or network managers.
- Government health schemes, public healthcare bodies and departments when proposing operational or benefit changes of the prescribed kind.
- Management services organisations, holding companies, private investment entities and joint ventures that own, control or manage a healthcare entity.
- Digital health, claims, eligibility, data or technology vendors where the proposed change can materially affect access, payment or essential service operation.
- Any other entity designated by regulation because of its control over an essential health-system function.

4.2 Core definitions

Term	Recommended policy definition
Material healthcare system change	A proposed transaction, arrangement, decision or series of related actions that meets a prescribed quantitative trigger or is reasonably likely to have a significant effect on access, affordability, quality, safety, continuity, competition, utilisation, public expenditure, workforce or system stability.
Change of control	The acquisition of direct or indirect power to direct management, governance, policy, assets or material contracting decisions, whether through ownership, voting rights, agreement, debt, management services or another mechanism.
Essential healthcare service	A service, benefit, medicine, supply function or infrastructure capability designated by regulation because interruption, loss or material restriction would create significant risk to health, access or system functioning.
Exclusive arrangement	A contractual or practical arrangement that requires, materially incentivises or effectively channels patients, members, prescriptions, referrals, purchases or service volume to one provider, supplier, network or related entity.
Affected persons	Residents, insured members, patients, caregivers or service users reasonably expected to experience a change in access, cost, benefit, location, wait time, choice or continuity.
Related transactions	Steps involving the same or affiliated parties, service line or strategic objective that occur within a prescribed aggregation period and should be treated as one change.

4.3 Public-sector and conflict safeguards

The framework should apply when a public body proposes a material change, because patients experience the consequences regardless of ownership. However, the ordinary Ministerial decision route should be adjusted where the Ministry of Health or Bermuda Health Council is itself the proponent. In those cases, an external assessment panel should perform or validate the review and Cabinet, or another Minister designated by statute, should make the final decision. Conflicts should be declared and published.

5. Institutional architecture and regulatory boundaries

5.1 Recommended health-sector model

Institution	Recommended role
Bermuda Health Council	Single filing point; jurisdictional screening; evidence collection; whole-system assessment; public and stakeholder engagement; specialist referrals; recommendation; publication; monitoring and compliance.
Minister of Health	Final public-interest decision: approve, condition, require modification, delay or refuse; publish reasons; direct monitoring and enforcement within statutory powers.
Competition and Regulatory Authority	Mandatory competition opinion on referred health changes; economy-wide competition conduct enforcement, cartel and abuse-of-dominance cases, and coordinated market studies. No separate ex ante health merger approval under the recommended model.
Bermuda Monetary Authority	Prudential soundness, controller fitness and insurer solvency. Advice should run concurrently and be incorporated into the health decision, while preserving any independent prudential approval required by financial-services law.
Chief Medical Officer and professional regulators	Clinical safety, medicines regulation, professional standards, public-health and licensing advice within their statutory mandates.
Attorney-General's Chambers	Legislative drafting, legal gateways, confidentiality, enforcement, appeal and conflict-resolution provisions.
Cabinet / alternative Minister	Decision where the Ministry or Health Council is the proponent, and resolution of cross-government policy conflicts.

5.2 Relationship with the proposed Competition Act 2026

The Home Affairs consultation currently proposes mandatory merger approval in essential sectors where combined market share would be 40 per cent or more, or where a health insurer acquires a health service provider. It also proposes a dedicated Healthcare Competition Unit within the CRA and describes the Health Council as a mandatory consultation partner without enforcement powers. By contrast, Cabinet has approved a health framework in which the Health Council reviews material changes and the Minister makes the final decision. These are materially different institutional designs.

Policy conclusion

A memorandum of understanding can coordinate information and timetables, but it cannot safely resolve two statutes that each give a different body final authority over the same healthcare transaction. Primary legislation should determine which regime has legal primacy.

5.3 Recommended statutory division of labour

1. All material healthcare changes, including healthcare mergers and vertical integrations, are notified once to the Health Council under the Bermuda Health Council Act.
2. The Health Council refers the competition component to the CRA whenever the proposal involves ownership, control, exclusivity, related-party steering, market concentration or another prescribed competition concern.

3. The CRA provides a written competition opinion within the Health Council timetable. That opinion is published with appropriate redactions and is a mandatory consideration, but it is not a second approval.
4. The Minister of Health issues the final ex ante health-sector decision under the broader public-interest test.
5. The Competition Act expressly excludes a healthcare transaction from duplicate merger approval where it is subject to a final decision under the Health Council Act.
6. The CRA retains full authority over cartels, abuse of dominance, anti-competitive agreements, misleading market conduct within its remit, post-implementation enforcement and market studies.
7. Health approval does not immunise conduct that was not required by the approval or its conditions. Conversely, conduct expressly required by a lawful health-sector condition should not be treated as a competition breach merely because the condition is followed.
8. The BMA retains independent prudential powers, but filings, evidence requests and timetables are coordinated through a joint protocol and shared data room where lawful.

5.4 Fallback model if a statutory carve-out is not accepted

If Government retains dual statutory approval, the minimum acceptable design should be a single filing, simultaneous review, one public timetable, mandatory consultation, a statutory rule against inconsistent conditions, and a clear conflict clause. A health change should not be permitted to proceed unless both the competition and health decisions are complete. This is less efficient than the recommended model and should be treated as a fallback, not the preferred design.

6. Classes of notifiable change

Class	Illustrative scope
Premiums, benefits and cost-sharing	Premium increases; deductible, co-payment, coinsurance or limit changes; benefit reductions; product closures; major eligibility or authorisation redesign.
Ownership, control and consolidation	Mergers, acquisitions, amalgamations, joint ventures, affiliations, asset transfers, management agreements, debt or governance rights that confer material influence.
Networks and referral arrangements	Exclusive or preferred provider/pharmacy networks, sole-source agreements, insurer-directed access, related-party steering, contracting platforms and network exclusions.
Essential services	Closure, relocation, suspension, downsizing, restructuring, outsourcing or material change in emergency, hospital, primary, cancer, mental health, maternity, renal, diagnostic, long-term, home, palliative or other designated services.
Pharmaceutical supply and distribution	Importer or distributor changes, designated medicine-class supply changes, specialty drug arrangements, cold-chain or compounding changes, concentration and shortage risk.
Reimbursement and payment models	Major fee reductions, payment-model changes, bundled or capitated arrangements, risk transfer, prior-authorisation rules and reimbursement changes capable of altering access or provider viability.
Digital, data and administrative systems	Eligibility, claims, authorisation, electronic records, interoperability, artificial intelligence or platform changes that materially affect patient access, benefit decisions, safety or essential operations.

Other structural changes	Any prescribed change or Ministerial call-in where there are reasonable grounds to expect material system effects.

The classes should be illustrative rather than exhaustive. The Act should establish the general definition and call-in power; regulations should list specific classes and thresholds so that the framework can respond to new business models without repeated primary legislation.

7. Proposed materiality thresholds

International practice combines absolute values, percentage changes and qualitative triggers. Bermuda's sector should not rely on market share alone. In a small island, a service can be essential even where the provider's financial size or market share appears modest. The proposed design therefore uses three review levels and a call-in safeguard.

7.1 Review levels

Level	Purpose	Typical outcome
Administrative filing	Provides visibility for routine but relevant changes, including annual premium filings below the formal review threshold.	Acknowledgement, data capture and no formal standstill unless called in.
Level 1 - screening review	Applies where a quantitative or qualitative trigger indicates possible but manageable system effects.	Clearance, standard safeguards, or escalation to Level 2.
Level 2 - full review	Applies to changes with significant scale, essential-service implications, control, exclusivity or high patient/system risk.	Detailed assessment, consultation and Ministerial decision.
Call-in	Prevents avoidance where a change falls below a stated number but is reasonably likely to have a material effect.	The Council gives written reasons and assigns Level 1 or Level 2.

7.2 Proposed starting thresholds for consultation

Change class	Proposed trigger
Premiums and benefit design	All changes filed annually; portfolio increase below 5% is normally administrative. Level 1: portfolio increase 5.0-9.9%, any product 10.0-14.9%, or expected member cost exposure changes by 5.0-9.9%. Level 2: portfolio increase at least 10%, any product at least 15%, cumulative portfolio increase at least 15% over 24 months, member cost exposure at least 10%, or removal/material restriction of an SHB or core benefit.

Ownership and control	Level 1: acquisition of 10-24.9% of voting/economic rights with governance or management influence; provisional transaction value at least $2M; combined Bermuda healthcare revenue/claims at least $5M; post-change service share at least 20%. Level 2: change of control or at least 25%; transaction value at least $5M; combined revenue/claims at least $10M; post-change market share at least 40%; any insurer acquisition/control of a provider, pharmacy or importer; or any transaction involving an essential service. Dollar thresholds require calibration before final regulations.
Exclusive or preferred networks	Level 1: affects at least 250 residents, at least 5% of an insurer's Bermuda members, or at least 5% of spend/volume in the relevant service or medicine class. Level 2: sole-source or exclusive access to an essential service/medicine; affects at least 1,000 residents, 10% of members or 10% of spend/volume; reduces qualified patient choices by at least 25%; or involves related-party steering.
Essential-service change	Permanent closure, relocation or restructuring of a designated essential service is always Level 2. Level 1: temporary disruption longer than 7 days or capacity reduction of 5.0-9.9% lasting more than 30 days. Level 2: capacity, staffed beds, operating hours or available slots reduced by at least 10%; expected wait time rises by at least 20%; typical travel time rises by at least 15 minutes; or at least 10% of service volume is shifted overseas or to another setting.
Pharmaceutical supply	Level 1: affects at least 250 patients or 5% of local spend/volume in a medicine class. Level 2: affects an essential/high-cost/specialty medicine class, at least 500 patients, at least 10% of class spend/volume, a sole or primary supplier, post-change supply share at least 40%, or a forecast interruption longer than 7 days.
Reimbursement and payment	Level 1: payment, authorisation or contracting change of at least 5% for an essential service or affecting at least 500 residents. Level 2: at least 10% change for an essential provider/service; affects at least 5% of an insurer's total claims; materially transfers financial risk; or is likely to destabilise essential capacity.
Digital, data and AI	Level 1: affects at least 500 residents or materially alters claims, referral or clinical workflow. Level 2: determines eligibility, denial, authorisation or clinical prioritisation for at least 1,000 residents, affects an essential service, or creates a material interoperability, outage, privacy or safety risk.

7.3 Anti-avoidance and threshold administration

- Any one applicable trigger should be sufficient; the thresholds are not cumulative requirements.
- Transactions or changes involving the same parties, affiliates, service line or strategic objective should be aggregated over 36 months.
- A material amendment after filing should require prompt notice and may restart or extend the review.
- Financial thresholds should be indexed annually and reviewed after the first two years of operation.
- The Council should issue non-binding jurisdictional guidance and maintain a published decision register to improve predictability.
- The Council or Minister should be able to call in a below-threshold change on written, published grounds where there is a reasonable likelihood of material impact.

8. Review pathway, timelines and procedures

8.1 Pre-filing and jurisdictional advice

Proponents should be encouraged to engage before formal filing, particularly for novel structures, distressed providers, essential services and changes that may require competition or prudential input. Pre-filing should be confidential and non-binding. The Health Council should ordinarily indicate within 10 business days whether the proposal appears notifiable and which review level is likely.

8.2 Notice period and standstill

- Standard notifiable changes: notice at least 90 calendar days before the proposed implementation date.
- Presumptively complex changes - major premium/benefit redesign, essential-service closure or relocation, control transactions and major exclusive networks: notice at least 120 calendar days before implementation.
- No notifiable change may be implemented until the process is complete and the written decision permits it.
- There should be no deemed approval solely because a deadline expires. If Government misses a deadline, the proponent should receive an expedited status conference and written revised timetable, without losing the standstill unless ordered by a court.

8.3 Standard procedure

Step	Action	Target
1. Filing	Proponent submits prescribed notice, impact assessment, implementation date, data and confidentiality schedule.	Day 0
2. Completeness	Council accepts the filing or requests specified missing items. The clock begins only when complete.	Within 10 business days
3. Public summary	Council posts a plain-language summary, review level and comment route, except where an emergency or lawful confidentiality reason requires delay.	Within 5 business days of completeness
4. Level 1 screening	Council applies risk criteria, consults regulators where needed and clears, sets standard safeguards, or opens Level 2.	Within 20 business days
5. Level 2 review	Detailed evidence, specialist opinions, public/targeted consultation, alternatives and mitigation assessment.	60 business days; one extension up to 30 business days
6. Recommendation	Council provides the Minister with findings, options, proposed conditions and draft reasons.	At end of review
7. Ministerial decision	Minister approves, conditions, requires modification, delays or refuses.	Within 10 business days
8. Publication and monitoring	Decision summary, reasons and conditions published; monitoring begins.	Within 5 business days after decision

8.4 Information requests and tolling

The Council should be able to require documents, data and explanations necessary for the review. The clock should pause only where the proponent has not supplied a material request by the stated deadline or agrees to tolling. Requests should be consolidated where possible, proportionate and linked to the assessment criteria. Third-party regulators should use a shared request process to avoid repeated demands for the same information.

8.5 Withdrawal, expiry and changed proposals

- The proponent may withdraw before decision, but reasonable external review costs remain payable where a fee regime applies.
- A materially changed proposal should be re-notified or formally amended, with a revised timetable.
- Approval should expire if implementation has not substantially commenced within 12 months, unless the Minister extends it on updated evidence.
- Linked implementation phases should be described at filing and may be subject to stage gates.

9. Public-interest assessment framework

The proponent should bear the responsibility of showing, on the best available evidence, that the proposed change is in the public interest and that material risks are avoidable or can be effectively mitigated. The review should compare the proposal not only with the current state, but also with realistic alternatives and the consequences of no change.

Domain	Core review question
Clinical quality and safety	Will standards, outcomes, escalation, incident management, competence and clinical governance improve or deteriorate?
Access and continuity	Who may wait longer, travel farther, lose a provider, face an interruption, be sent overseas or encounter a new administrative barrier?
Affordability and financial protection	What happens to premiums, co-payments, balance billing, out-of-pocket exposure, employer costs and public subsidies?
Equity	Are older adults, people with disabilities, underinsured residents, public payers, lower-income households affected differently?
Patient choice and experience	Is meaningful choice preserved? Are transitions, communications, exceptions and complaints processes adequate?
Workforce and capacity	Are staffing, training, recruitment, succession, locum, pharmacy, laboratory, emergency and other dependencies sufficient?
System integration and data	Will records, referrals, claims, medication information, data-sharing, cybersecurity and interoperability support safe continuity?
Cost and value	What are the whole-system costs, including fixed costs, duplication, overseas care, family burden, charities, public expenditure and cost shifting?
Competition and market power	Will the change reduce alternatives, create exclusion, strengthen related-party steering, increase bargaining power or create barriers to entry?
Financial sustainability	Are the entities and affected services viable? Could the change destabilise an essential provider, insurer or supply chain?
Implementation readiness	Are governance, milestones, funding, communications, transition and risk controls credible and enforceable?
Strategic alignment	Is the change consistent with UHC, core benefits, health strategy, prevention, digital priorities and sustainable small-island service planning?
Public and stakeholder evidence	What do affected patients, professionals, employers, public payers and communities identify as benefits, risks or alternatives?

9.1 Recommended decision standard

Public-interest test - A change should be approved only where the Minister is satisfied that it is unlikely to create unmitigated material harm to patients or the health system, that claimed benefits are credible and reasonably achievable, and that enforceable conditions can address any residual risks. A change may be refused where material harm cannot be mitigated, the proposal is inconsistent with essential system objectives, or the proponent has not supplied sufficient reliable evidence after a reasonable opportunity to do so.

10. Submission and evidence requirements

A single prescribed notice should be supported by a proportionate impact assessment. The Health Council should publish standard forms and category-specific schedules. Proponents should not be required to recreate data already lawfully held by Government where secure sharing is possible.

Submission area	Minimum content
Proposal and parties	Legal entities, affiliates, beneficial ownership, governance, advisers, transaction documents, implementation date and contact persons.
Rationale and objectives	Problem being addressed, expected benefits, strategic case, alternatives considered and reasons alternatives were rejected.
Affected population	Number and characteristics of residents, members, patients, providers and public programmes affected; geographic and equity analysis.
Current-state baseline	Volumes, capacity, wait times, outcomes, prices, premiums, member costs, staffing, market shares, complaints and service dependencies.
Future-state impact	Expected changes in access, cost, utilisation, patient flows, workforce, quality, choice, competition and public expenditure over at least three years.
Financial and actuarial evidence	Business case, source and use of funds, savings, revenue, claims, premium impact, sensitivity analysis, financial sustainability and distribution of gains/losses.
Clinical and operational plan	Standards, staffing, licences, escalation, supply, facilities, accreditation, emergency continuity, data and implementation milestones.
Risk and mitigation register	Material risks, likelihood, severity, responsible owner, mitigation, trigger, contingency and residual risk.
Patient and stakeholder plan	Engagement already undertaken, communications, transition support, exceptions, accessibility and complaint handling.
Monitoring proposal	KPIs, baseline, reporting frequency, data owner, audit rights and proposed duration of conditions.
Confidentiality schedule	Itemised redaction requests with legal and commercial justification; personal health information separately protected.

10.1 Category-specific requirements

- Premium and benefit changes: actuarial memorandum, claims trend, utilisation, reserves, administrative costs, profit/margin, benefit payout, product-level impact and member distribution.
- Transactions: ownership/control documents, valuation, financing, market definition, efficiencies, integration plan, service commitments and alternatives.

- Essential-service changes: clinical case for change, capacity and demand, travel/wait impact, workforce, emergency continuity, public engagement and return/transition plan.
- Pharmaceutical changes: drug classes, patient counts, acquisition/landed cost, supply routes, cold chain, stock resilience, exception and medication-safety plan.
- Digital/AI changes: intended use, decision authority, validation, bias/equity assessment, human oversight, cybersecurity, downtime, interoperability and appeal routes.

11. Stakeholder participation, transparency and confidentiality

11.1 Proportionate engagement

Level 1 reviews may be completed through targeted consultation where the issues are narrow. Level 2 reviews should normally include a public notice and at least 15 business days for comment, supplemented by direct engagement with affected patients, provider groups, employees, public payers, employers, unions and professional bodies. Engagement should be accessible to older residents and people who are not comfortable with online-only processes, including telephone, written, large-print and in-person options where appropriate.

11.2 Publication

- Plain-language notice summary, proposed date and review level.
- Non-confidential impact assessment or Council-prepared summary.
- Public comment route and closing date.
- Council recommendation summary and any specialist opinions, subject to lawful redaction.
- Ministerial decision, reasons, conditions and monitoring requirements.
- Annual register of notifications, review times, decisions, compliance and outcomes.

11.3 Confidentiality

The Act should create a clear confidentiality regime and lawful gateways for information sharing among the Health Council, Ministry, CRA, BMA, Chief Medical Officer and other designated regulators. The proponent should identify confidential material item by item and explain the likely harm from disclosure. The Council should decide requests, publish a redaction log and protect personal health information absolutely. Commercial confidentiality should not prevent publication of the proposal's essential terms, patient impact, decision reasons and conditions.

12. Decisions, conditions and post-implementation monitoring

12.1 Available decisions

Decision	When appropriate
Approve	No material adverse effect is identified, or benefits clearly outweigh minor risks without special safeguards.
Approve with conditions	The change is supportable but specific, enforceable safeguards are needed.
Require modification	A different scope, timetable, benefit design, network rule, governance arrangement or implementation plan is necessary before approval.
Delay	Additional evidence, consultation, workforce, infrastructure, transition or coordination is required before implementation.

Refuse	Material harm is likely and cannot be acceptably mitigated, the proposal conflicts with essential system objectives, or reliable evidence remains insufficient.
Interim approval	Urgent circumstances justify temporary implementation subject to strict time limits, safeguards and retrospective review.

12.2 Conditions

Conditions should be necessary, proportionate, measurable and connected to identified risk. They may apply for a defined period, contain review points and be incorporated into insurer or provider licensing conditions where lawful. The framework should permit financial, service, access, data, governance, workforce and competition-related safeguards.

12.3 Monitoring

- Standard reporting at 6, 12 and 24 months for major changes, with longer monitoring up to five years where ownership or market structure is altered.
- Baseline and target KPIs set before implementation.
- Independent audit rights and access to underlying data.
- Patient complaints and access events incorporated into monitoring.
- Power to vary conditions where evidence shows a material unforeseen effect, subject to procedural fairness.
- Published monitoring summaries that protect confidential information.

13. Emergency and expedited procedures

An advance-review regime must not prevent urgent action needed to protect patients. However, emergency treatment should be a controlled procedure rather than a broad exemption. The proponent should show that delay would create an immediate and significant safety, supply, service-continuity or financial-distress risk and that the proposed action is necessary and proportionate.

Emergency element	Recommended rule
Trigger	Immediate threat to patient safety, public health, essential medicine supply, critical service continuity or imminent failure of an essential entity.
Notice	As early as practicable, with written reasons, evidence, duration and safeguards.
Decision	Council recommendation and Ministerial interim authorisation on an expedited timetable, ordinarily within 5-10 business days where evidence is complete.
Duration	Temporary approval for no more than 90 days unless extended on fresh evidence.
Safeguards	Continuity, communication, equity, price, workforce, data and reporting conditions.
Follow-up	Retrospective review and full process before the temporary change becomes permanent.

14. Compliance, enforcement and review rights

14.1 Core compliance duties

- Notify accurately and on time.
- Do not implement a notifiable change before the decision or contrary to a standstill direction.
- Supply complete and non-misleading information.
- Comply with decision conditions, reporting and monitoring.
- Notify material amendments, delays or abandonment promptly.

14.2 Enforcement architecture

The Act should authorise proportionate civil penalties, court orders and licensing consequences for failure to notify, premature implementation, false information and breach of conditions. Penalty levels should be calibrated with the existing Health Council enforcement framework and the financial scale of the entity. For deliberate implementation before approval, a turnover-linked maximum should be considered so that a penalty is not merely a cost of doing business. Daily penalties may be appropriate for continuing non-compliance.

- Administrative warning and cure period for minor first-time procedural breaches where no patient harm is created.
- Civil penalty and daily continuing penalty for failure to notify or comply.
- Ministerial or court order to stop, suspend or reverse implementation where practicable and necessary.
- Licence conditions, restrictions or referral to the relevant regulator.
- Publication of enforcement outcomes after due process.
- No automatic criminalisation of ordinary filing errors; criminal offences should be reserved for deliberate obstruction, false evidence or serious knowing breach if Cabinet and AG Chambers consider them necessary.

14.3 Procedural fairness and review

The proponent should receive the material findings, an opportunity to respond, reasons for the decision and access to judicial review. A short administrative reconsideration route should be available for obvious factual error or genuinely new information, without becoming a full merits appeal that undermines certainty. An appeal should not automatically suspend patient-protection conditions unless the court orders otherwise.

15. Resourcing, fees and operational capability

15.1 Material Change Review Unit

The Health Council should establish a ring-fenced review function with clear conflict controls and direct access to specialist advice. At minimum, the initial operating model should provide approximately 1.5 to 2.0 dedicated full-time-equivalent capacity, supported by existing Council expertise and an external panel.

Capability	Initial requirement
Programme leadership	Senior health economist/regulatory lead responsible for case management, methods, recommendations and inter-agency coordination.
Analysis	Policy/market analyst able to assess utilisation, claims, access, competition, financial and equity impacts.
Legal/regulatory	Dedicated or retained legal capability for jurisdiction, confidentiality, conditions, enforcement and procedural fairness.

Clinical and actuarial	Standing external panel or secondment arrangements for clinical, pharmacy, actuarial, accounting, workforce, technology and competition expertise.
Data and case system	Secure portal, document room, case clock, public register, confidentiality controls and monitoring dashboard.
Governance	Internal review committee, declared conflicts, quality assurance and CEO/Board oversight consistent with statutory independence.

15.2 Fees

A modest, transparent cost-recovery model is preferable to charging the public for commercial transactions. Administrative filings should carry no fee. Level 1 and Level 2 reviews may carry fixed fees, with capped recovery of exceptional external expert costs approved in advance. Public bodies, charities, distressed essential services and proposals initiated to preserve access should be eligible for waiver or reduction. Final fee amounts should follow a regulatory impact assessment and consultation.

16. Implementation roadmap following Cabinet approval

Period	Actions
Immediate: 0-30 days	Establish an Implementation Steering Group; confirm policy owner and project plan; issue formal MoH response to the Competition Act consultation by 15 September 2026; obtain Cabinet/AG direction on health-sector primacy; draft interim voluntary notification protocol; identify staffing and budget.
30-90 days	Targeted consultation with insurers, providers, pharmacies, BHB, BCHC, professional bodies, BMA, Home Affairs/CRA team, public payers, employers, unions, patient and senior groups; calibrate thresholds using three years of Bermuda data; draft forms, guidance and assessment methodology.
3-6 months	Finalise policy positions; issue drafting instructions; develop Bill and regulations; complete legal gateways and coordination clauses; build portal/case-management minimum viable product; appoint external panel; prepare fee and resource proposal.
6-9 months	Legislative consultation and passage process; finalise MOU and operating protocols; staff training; publish draft guidance; conduct tabletop testing using historic or hypothetical cases.
9-12 months	Commence the statutory framework with a short implementation window; accept early voluntary filings; publish public guidance and decision templates.
12-24 months	Publish first annual report; review thresholds, turnaround times, stakeholder burden, conditions and outcomes; make regulatory adjustments; conduct independent evaluation after two years.

16.1 Interim protocol before enactment

Cabinet approval does not itself create the statutory power to compel notification or refuse a change. Until legislation commences, the Ministry and Health Council should publish a voluntary protocol requesting at least

60 days' notice of changes that would clearly fall within the proposed framework. Existing lawful data, licensing, formulary and insurer information powers may support analysis, and proponents may provide written undertakings not to implement during review. The interim protocol must state clearly that it does not substitute for legislation or create powers that do not yet exist.

17. Consultation programme and questions

17.1 Stakeholders

- Licensed insurers, approved schemes, employers and insurance associations.
- BHB, BCHC, community providers, care homes, home-care providers, diagnostic services and provider associations.
- Pharmacies, importers, wholesalers, distributors, prescribers and professional councils.
- BMA, Ministry of Home Affairs/CRA design team, Attorney-General's Chambers, Ministry of Finance, public payer programmes, CMO and other regulators.
- Patient groups, charities, seniors' organisations, disability organisations, unions and the wider public.
- Technology, data and digital-health partners where changes may affect access or claims.

17.2 Consultation questions

1. Are the proposed classes of notifiable change complete and clear?
2. Which quantitative thresholds best reflect Bermuda's market and service scale?
3. Should all annual premium and benefit changes be filed, with only larger changes entering formal review?
4. Which services and medicine classes should be designated essential from commencement?
5. Is 90 days adequate for standard notice and 120 days for complex changes?
6. What information can be drawn from existing statutory returns rather than newly collected?
7. What level of public consultation is proportionate for each review level?
8. What fee structure avoids discouraging beneficial access-preserving changes?
9. What conflict process should apply where Government or the Health Council is the proponent?
10. Do stakeholders support the recommended single-front-door model and health-sector carve-out from duplicate CRA merger approval?
11. What transition period is needed for existing arrangements and transactions already in development?
12. What outcomes should be measured after the framework commences?

18. Legislative drafting directions

The Cabinet paper recommends a new Part IIIB in the Bermuda Health Council Act 2004. The Act should contain the durable legal architecture, while regulations should contain adjustable categories, numbers, forms and deadlines.

18.1 Matters for the Act

- Purpose and public-interest objectives.
- Definitions of material healthcare system change, prescribed entity, control and essential service.
- Duty to notify and restriction on implementation before decision.
- Health Council powers to screen, obtain information, consult, review and monitor.
- Duty to provide a recommendation and material findings to the Minister.
- Ministerial powers to approve, condition, require modification, delay, refuse and issue interim approval.

- Power to impose, vary and enforce conditions.
- Call-in and anti-avoidance powers for related transactions.
- Confidentiality, lawful information sharing and publication duties.
- Emergency process, offences/civil penalties and court orders.
- Reconsideration and judicial review.
- Alternative decision-maker where the ordinary decision-maker is conflicted.
- Regulation-making power and periodic statutory review.
- Express relationship with the Competition Act and BMA statutes, including no duplicate health merger approval under the recommended model.

18.2 Matters for regulations

- Prescribed entities and notifiable change classes.
- Thresholds, aggregation periods and essential-service schedule.
- Forms, supporting evidence and confidentiality schedules.
- Administrative filing, Level 1 and Level 2 procedures.
- Notice periods, completeness, review clocks, tolling and extensions.
- Public and targeted consultation requirements.
- Emergency, distressed-entity and temporary-change procedures.
- Fees, waivers, monitoring and reporting.
- Penalty bands and compliance notices consistent with the Act.
- Transitional arrangements and existing pipeline cases.

18.3 Drafting issue requiring early Cabinet settlement

The Health Council Act and Competition Act should not both purport to give different bodies final approval power over the same healthcare merger or structural change. The drafting instructions for both Bills should include a coordinated schedule defining the single filing route, referral duties, final decision-maker, enforcement boundaries and conflict rule.

Annex A. International comparator review

The comparator review supports a Bermuda model that combines early notice, staged review, adjustable quantitative thresholds, qualitative essential-service triggers, public engagement, regulator coordination, conditions and post-implementation monitoring. No single jurisdiction is copied; the design is scaled for Bermuda.

A1. Health transaction oversight

Jurisdiction	Timing	Threshold/scope	Decision design	Takeaway
California - OHCA	90-day notice. Initial review up to 45 days; decision on full review within 60 days.	Entity thresholds include $25M revenue/assets, or $10M when transacting with a $25M entity. Transaction triggers include $25M value, $10M or 20% revenue increase, 25% asset transfer, control/governance transfer and serial transactions.	Public notice and confidentiality process. Certain transactions already reviewed by other state regulators are exempt, which avoids duplication.	Use multiple triggers, include indirect controllers and serial transactions, and write explicit no-duplication rules.
Oregon - HCMO	Notice at least 180 days before transaction. Preliminary review and, where necessary, comprehensive review; approval can include conditions and follow-up.	At least one party averages $25M revenue and another $10M, with qualitative access/cost tests for out-of-state involvement.	Public-interest review covers cost, equity, access and quality. Domestic insurer transactions are coordinated with the insurance regulator, which makes the final insurer determination.	Coordinate specialist reviews and monitor outcomes after closing; use an emergency route for continuity risk.
Massachusetts - HPC	60-day notice; 30-day preliminary review. Full cost and market impact review may follow, with publication before completion.	Material changes include provider-payer affiliations, hospital mergers, insolvent provider acquisitions and near-majority market share; provider organisations below the statutory revenue/panel threshold may be exempt.	Strong transparency and market analysis, but the HPC review is not itself a broad approval regime.	Bermuda should retain the transparency and staged screening, but needs a real approval power because of system scale and irreversibility.

A2. Service change and premium oversight

Jurisdiction	Approach	Takeaway
England - NHS service change	Substantial change is assessed qualitatively, including access, patient numbers, duration, wider impact and change of setting. Public/local authority consultation applies; urgent temporary changes have a separate route and return plan.	Do not rely only on financial thresholds. Essential-service closure, relocation and access deterioration should be independently notifiable.
Australia - private health insurance	Every premium increase requires Ministerial approval. The Department assesses evidence and actuarial opinion, while APRA advises on prudential consequences. The Minister may require resubmission and must approve unless satisfied the increase is not in the public interest.	Coordinate affordability and prudential review; assess evidence, benefit payout and system sustainability together.
United States - federal rate review	The federal default threshold for reasonableness review is 15%, while states may apply stricter standards. Significant increases require public justification and expert review.	Use a lower Bermuda threshold because the market is concentrated, but retain a higher trigger for full review and transparent justification.

A3. International design conclusions

- A 5- or 10-working-day merger screen, as proposed in the current Bermuda competition consultation, is not sufficient for a whole-system healthcare review involving clinical, actuarial, workforce and patient evidence.
- Ninety days is a reasonable standard notice period between the 60-day Massachusetts and 180-day Oregon models, with 120 days for complex Bermuda changes.
- Quantitative thresholds should be supplemented by essential-service, access and call-in triggers.
- The strongest regimes distinguish preliminary screening from comprehensive review.
- Explicit statutory coordination or exemptions are better than relying on parties to navigate duplicate regulators.
- Public summaries, reasons and follow-up monitoring improve legitimacy and test whether promised benefits are delivered.

Annex B. Proposed Bermuda threshold matrix

Indicator	Administrative / normally exempt	Level 1	Level 2
Premium - portfolio average	<5% annual administrative filing	5.0-9.9%	>=10%
Premium - individual product/tier	<10% unless other trigger	10.0-14.9%	>=15%
Cumulative premium change	N/A	Council discretion	>=15% over 24 months
Member cost-sharing / actuarial value	<5%	5.0-9.9%	>=10% or material SHB/core-benefit restriction
Ownership / voting / economic rights	<10% without influence	10-24.9% with influence	>=25% or any change of control
Transaction value - provisional	<$2M	$2M-$4.99M	>=$5M
Combined revenue/claims - provisional	<$5M	$5M-$9.99M	>=$10M
Post-change market/service share	<20%	20-39.9%	>=40%
Vertical insurer-provider/pharmacy/importer transaction	N/A	N/A	Always full review
Network affected persons	<250	250-999	>=1,000 or essential service/medicine
Network member or spend/volume share	<5%	5.0-9.9%	>=10% or choice reduction >=25%
Essential service capacity change	<5%	5.0-9.9% lasting >30 days	>=10%, permanent closure/relocation/restructure
Wait-time change	Minor	Council discretion	Expected increase >=20%
Travel/access change	Minor	Council discretion	Typical travel increase >=15 minutes
Pharmaceutical affected patients	<250	250-499	>=500 or essential/high-cost class
Pharmaceutical class spend/volume	<5%	5.0-9.9%	>=10%, sole supplier or post-share >=40%
Reimbursement change	<5%	5.0-9.9%	>=10% for essential service or >=5% of total insurer claims
Digital/data affected residents	<500	500-999	>=1,000 or essential/eligibility/denial function

Note: Financial and population thresholds are proposed starting points for consultation. Before regulations are finalised, the Health Council should test them against three years of Bermuda claims, premium, provider revenue, service-volume and market-share data. Qualitative essential-service and patient-safety triggers override financial size.

Annex C. Process map and standard timelines

Stage	Output	Target
Optional pre-filing	Scope discussion; likely threshold; regulator referrals identified.	0-10 business days
Formal notice	Filed 90 days before standard change or 120 days before presumptively complex change.	Day 0
Completeness	Accept or issue one consolidated deficiency notice.	By business day 10
Public summary	Plain-language notice and comment route.	Within 5 business days after completeness
Level 1 screening	Risk screen; CRA/BMA/CMO referral as relevant.	20 business days
Clearance route	Approve/standard safeguards; Ministerial confirmation where prescribed.	Usually within 30-40 business days total
Level 2 review	Detailed evidence, consultation, alternatives, mitigation and conditions.	60 business days; exceptional +30
Recommendation	Council report to Minister.	At end of review
Decision	Approve, condition, modify, delay or refuse.	10 business days
Monitoring	6/12/24 months; longer for ownership and major structural changes.	As conditioned

Annex D. Minimum notification dataset

Dataset section	Required information
Identification	Entity names, licence numbers, parent/affiliate structure, beneficial owners, directors/controllers, contact and advisers.
Change description	Type, legal form, affected service/benefit/medicine, rationale, agreements, implementation date and phases.
Affected population	Residents/members/patients by age, insurer, payer, geography and relevant equity characteristics; providers and employees affected.
Financial	Three-year revenue/claims/cost history, transaction value, financing, forecasts, premiums, member costs, public cost and sensitivity analysis.
Market and choice	Current/post-change market shares, alternatives, network criteria, exclusivity, ownership links, referral/steering and entry barriers.
Access and service	Locations, hours, capacity, waits, travel, overseas referrals, closures, transition and continuity.
Quality and safety	Outcomes, incidents, standards, licences, accreditation, clinical governance, emergency and escalation.
Workforce	Current/proposed staffing, vacancies, competencies, recruitment, locum/backup and workforce impact.
Supply and infrastructure	Facilities, equipment, medicines, suppliers, redundancy, cold chain, maintenance and disaster continuity.
Digital and data	Systems, interoperability, data flows, cybersecurity, privacy, automation/AI, downtime and appeals.
Alternatives	No-change scenario, options assessed, reasons for preferred option and less restrictive alternatives.
Mitigation and monitoring	Risk register, conditions offered, KPIs, reporting, audit and responsible officers.
Confidentiality	Itemised requests, legal basis and proposed public summary.

Annex E. Inter-regulator coordination protocol

The following principles should be reflected in legislation where necessary and then operationalised through an MOU. The MOU must not be used as a substitute for statutory primacy.

1. Single filing: the Health Council receives the health notification and circulates relevant material through lawful gateways.
2. Early triage: within five business days of completeness, the Council identifies whether CRA, BMA, CMO, Pharmacy, professional or other specialist advice is required.
3. One request plan: agencies agree a consolidated information request and avoid duplicate demands.
4. Concurrent review: specialist assessments run within the Health Council clock rather than sequentially.
5. Defined tests: CRA addresses competition; BMA addresses prudential soundness; CMO/professional regulators address clinical or medicines safety; Health Council integrates all domains.
6. Written opinions: specialist agencies provide reasoned opinions by agreed deadlines and identify any mandatory statutory constraints.
7. One health decision: the Minister of Health makes the final health public-interest decision under the recommended model.
8. No inconsistent conditions: any separate prudential or licensing condition is reconciled before the final decision is issued.
9. Confidentiality and data security: shared access is role-based, auditable and limited to lawful purposes.
10. Post-decision referrals: suspected competition or licensing breaches may be referred for separate enforcement without reopening the health approval unless the approval was obtained by misrepresentation or conditions are breached.
11. Dispute escalation: unresolved agency disagreement is escalated to the Permanent Secretaries and Attorney-General's Chambers, and if necessary to Cabinet, without informal public conflict.

Annex F. Illustrative decision conditions

Condition domain	Illustrative condition
Access and continuity	Maintain specified locations/hours/capacity; no interruption; transition support; automatic exceptions for clinical/geographic need; minimum notice to patients.
Pricing and benefits	Premium cap or revised increase; no network penalty for designated benefits; price transparency; regulated reimbursement or no balance billing.
Choice and competition	Any-willing-qualified-provider route; non-exclusive contracting; objective network criteria; prohibition on related-party steering without disclosure/choice; divestment or ring-fencing where legally available and necessary.
Quality and safety	Minimum staffing, credentialing, clinical protocols, incident reporting, external review, emergency escalation and accreditation milestones.
Workforce	Retention commitments, training, redundancy, locum/backup plans, consultation with affected employees and limits on unsafe reductions.
Supply resilience	Multiple suppliers/routes, minimum stock, shortage reporting, cold-chain monitoring and emergency sourcing.
Data and interoperability	Shared records, standard data submission, patient access to records, cybersecurity controls, audit and downtime plans.
Financial sustainability	Restricted dividends/distributions for a period, minimum reinvestment, reserve commitments, separate accounts, funding guarantees or service-continuity bond.
Governance	Independent director or committee, conflict disclosure, patient representation, named accountable officer and escalation route.
Monitoring	Defined KPIs, 6/12/24-month reports, independent audit, publication, review point and power to vary conditions.

Annex G. Source notes

Internal Bermuda policy sources

- Ministry of Health, Cabinet Memorandum: Advance Review and Approval Framework for Material Changes in Bermuda's Healthcare System (2026).
- Ministry of Health, Minister of Health Announces New Advance Review Procedures to Protect Patient Choice, Fair Competition, and Affordability (draft press release, 2026).
- Bermuda Health Council, Bermuda Pharmacy Sector Status Report and Action Plan (draft, May 2026).
- Bermuda Health Council, Oncology Feasibility Study - Phase I (May 2026).

Public comparator and policy sources

- Government of Bermuda, Ministry of Home Affairs - Promoting Competition and Market Fairness in Bermuda: Proposed Competition Act 2026, Consultative Policy Document (August 2026).
- California Department of Health Care Access and Information - Material Change Notice and Cost and Market Impact Review FAQs.
- Oregon Revised Statutes, sections 415.500-415.501 - Health Care Market Oversight.
- Oregon Health Authority - Health Care Market Oversight transaction notice and review resources.
- Massachusetts General Laws, Chapter 6D, section 13 / Acts of 2012, Chapter 224 - material change notice and cost and market impact review.
- NHS England - Planning, assuring and delivering service change for patients (updated 25 June 2026).
- Australian Government Department of Health, Disability and Ageing - Apply to increase private health insurance premiums.
- US Centers for Medicare & Medicaid Services - Review of Insurance Rates and State-Specific Threshold Proposals.

Comparator thresholds are used as design evidence, not as direct legal precedents. All proposed numerical triggers in this paper require data calibration, consultation and legal drafting.

Contact us

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

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