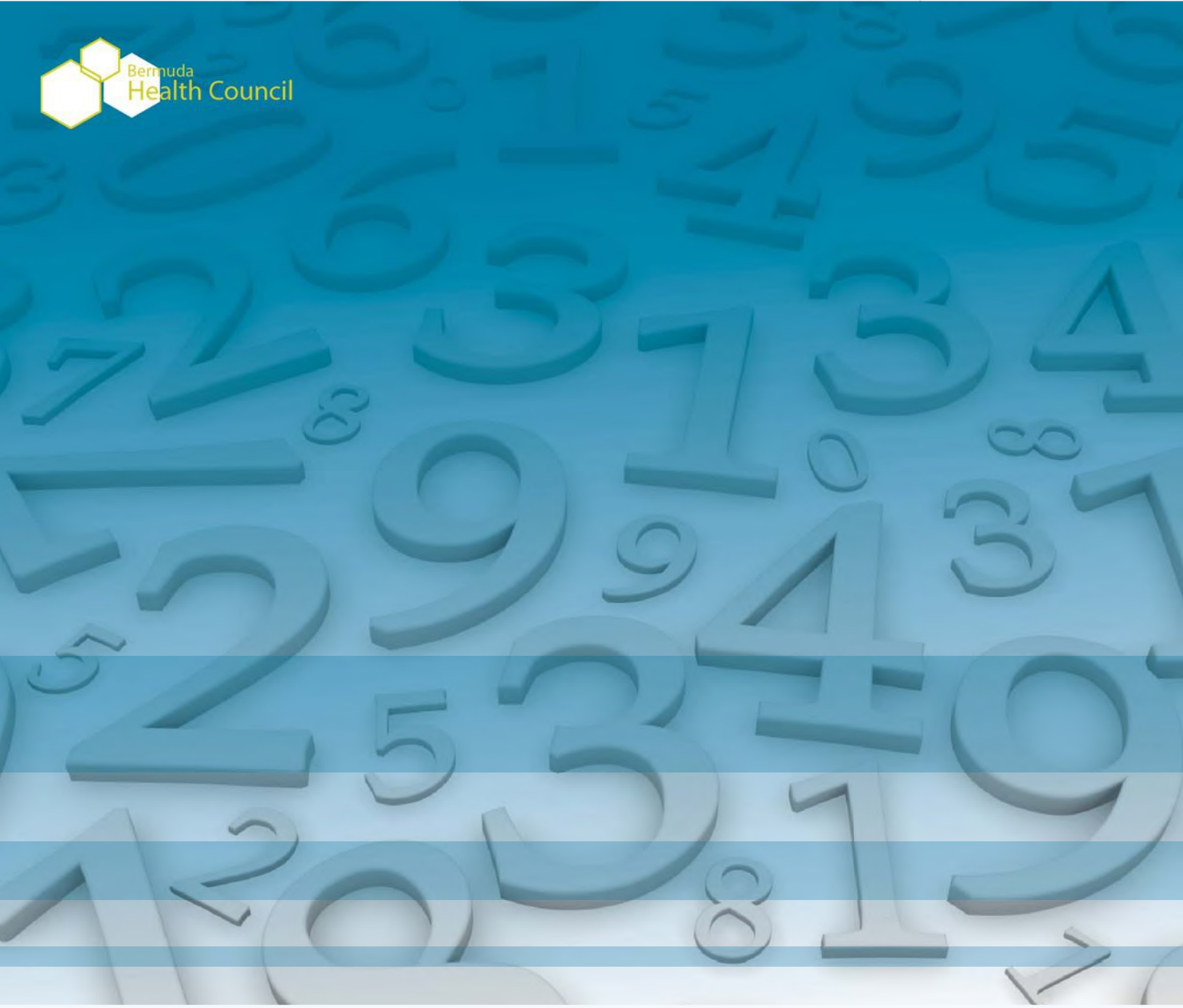
Bermuda Health Council



2014

ACTUARIAL REPORT

for the Bermuda Health Council

2014 Actuarial Report for the Bermuda Health Council

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.

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Abridged Version

2014 Actuarial Report for the Bermuda Health Council

- The Standard Hospital Benefit (SHB)
- The Mutual Reinsurance Fund (MRF)

April 2015

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Introduction

Morneau Shepell has been engaged by the Bermuda Health Council (Health Council) and we are pleased to present our report on the Fiscal 2014 review (i.e. the period April 1, 2013 to March 31, 2014) of the following programs:

- the Standard Hospital Benefit (SHB), and
- the Mutual Reinsurance Fund (MRF).

The purpose of this report is:

- to review the statistical and claims information submitted by health insurers and approved schemes, as it relates to the SHB
- to review the financial condition of the MRF
- to comment on trends over the Fiscal 2013 / Fiscal 2014 period
- to recommend premium rates that are to take effect in Fiscal 2016
- to analyze any changes in SHB and MRF benefit provisions that are under consideration

In preparing this report we relied on the documentation and information provided to us by the Health Council.

Section A – Summary & Premium Recommendation

A summary of Fiscal 2014 and Fiscal 2013 insured headcount, claims and costs per-capita is tabled below:

A.1. : Standard Hospital Benefit Insured Headcount

	Fiscal 2014	Fiscal 2013	% Change
Grand Total	48,580	49,481	-1.8%

A.2. : Standard Hospital Benefit Claims Data

Claim Amounts	Local			Overseas		Overall	
(in $ '000s)	In-Patient	Out-Patient	Total	In-Patient	Out-Patient	Total	Total
Fiscal 2013	$33,598	$83,075	$116,673	$13,325	$17,410	$30,375	$147,408
Fiscal 2014	$38,864	$82,218	$121,082	$13,755	$24,271	$38,025	$159,107
Increase	16%	-1%	4%	3%	39%	25%	8%

A.3. : Standard Hospital Benefit Cost per-capita and Loss Ratios

Fiscal 2014		Fiscal 2013		
Cost Per-Capita	Loss Ratio	Cost Per-Capita	Loss Ratio	Cost Per-Capita Increase
$273	97%	$248	105%	10%

The Fiscal 2014 and Fiscal 2013 loss ratios are based on a Standard Premium Rate of $282.27 and $236.73 respectively. The Standard Premium Rate increased at a faster pace than the total per-capita claim costs (19% for the Standard Premium Rate and 10% for the claims). This has led to an improvement in the loss ratio from 105% to 97%.

A.4. : Standard Premium Recommendation (including the MRF)

		Inc. %	Standard Hospital Benefit	Mutual Reins. Fund	Total
Fiscal 2015 Premium			$272.67	$29.18	$301.85
1.	Increase in BHB Fees	1.00%	$2.73	$0.00	$2.73
2.	Local Change in Utilization / Inflation / Services	0.00%	$0.00	$0.00	$0.00
3.	Future Changes in Benefit Provisions	(0.40%)	($1.07)	$0.00	($1.07)
4.	Allowance for SHB Claims Administration	0.00%	$0.00	$0.00	$0.00
5.	Funding of a Pilot Primary Care Program	21.2%	$0.00	$6.19	$6.19
6.	Various Transfers	97.2%	$0.00	$28.37	$28.37
Recommended Fiscal 2016 SPR			**$274.33***	**$63.74**	**$338.07**
% Change in Premium			**0.6%**	**118.4%**	**12.0%**
$ Change in Premium			**$1.66**	**$34.56**	**$36.22**

* The multiplier for those over age 65 and not eligible for the government subsidy is 4 times the Standard Premium Rate.

Please refer to the sections that follow for notes on the above recommendation.

Respectfully submitted,

Howard Cimring, FFA, FCIA

Partner

MORNEAU SHEPELL

April, 2015

Section B – The Standard Hospital Benefit

B.1. : Introduction

The Standard Hospital Benefit (SHB), as defined by the Standard Hospital Benefits Regulations 1971, consists of inpatient, outpatient, home medical services and other benefits. The SHB is the minimum package of benefits which must be provided within each employer sponsored or health insurance provider's health plan. Further, it is compulsory for each employed (including self-employed) person to have health insurance.

A Standard Premium Rate (SPR) for the Standard Hospital Benefits is determined annually by the Ministry of Health, Seniors and Environment, after taking advice from the Bermuda Health Council which commissions an actuarial review for the SPR. The SPR is the ceiling rate that can be charged to insured persons for the Standard Hospital Benefits. A health insurance provider cannot charge more than the SPR for the Standard Hospital Benefits. An employee cannot be required to pay more than half of the SPR for SHB coverage. The SPR allows all insured persons to access the same basic level of SHB health insurance coverage for the same price regardless of their health status.

The SPR is set with reference to the claims experience of all the insured participants. As such, the claims experience (in respect of the SHB component only) across all the health insurance providers is pooled together and a single premium rate reflective of the pooled experience is determined.

B.2. : Fiscal 2014 Claims and Statistical Data

We have analyzed the Fiscal 2014 and Fiscal 2013 health insurer and approved scheme[1] submissions to the Health Council. A summary of certain data elements and our analysis is tabled below:

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[1] An approved scheme is a scheme established by an employer to cover its employees and retirees.

Table 1: Headcount

	Average Headcount				
	2014	% Total	2013	% Total	% Change
Insurers	37,915	78%	39,193	79%	-3.3%
Approved Schemes	10,665	22%	10,288	21%	3.7%
Grand Total	**48,580**	**100%**	**49,481**	**100%**	**-1.8%**

In Fiscal 2014, there are five insurers and three approved schemes. In Fiscal 2014, 38% of the insured population was aged 55 and over (compares with 37% in Fiscal 2013). The estimated average age of the insured population in Fiscal 2014 is 50.7 years old (a 0.7 year increase over Fiscal 2013).

The claims are summarized below:

Table 2: Claim Amounts

(in $ '000s)	Local			Overseas			Overall
	In-Patient	Out-Patient	Total	In-Patient	Out-Patient	Total	Total
Fiscal 2013	$33,598	$83,075	$116,673	$13,325	$17,410	$30,375	$147,408
Fiscal 2014	$38,864	$82,218	$121,082	$13,755	$24,271	$38,025	$159,107
Increase	16%	-1%	4%	3%	39%	25%	8%
Increase in utilization	18%	1%	6%	2%	38%	22%	9%
Percentage 2014 Local Claims							76%
Percentage 2014 Overseas Claims							24%

The increase in utilization represents the increase in the incidence of claims and the use of services (new or otherwise). It has been derived by adjusting the increase in claims by the change in the average headcount (see Table 1) and an estimated increase in the cost of services (i.e. the change in the provider fees) of zero percent for local fees and three percent for overseas fees. Due to a significant increase in local in-patient claims, the local utilization increased by 6% (the prior period's increase was 3%). There has also been a significant increase in overseas utilization of

22% (whereas the prior period indicated a decline of 9%). With effect from April 1, 2014 (i.e. the Fiscal 2015 period), the SHB excluded portability.

When compared with Fiscal 2013, the Fiscal 2014 Bermuda Hospital's Board (BHB) in-patient admissions (see Appendix 2) have declined by 4% however the Diagnostic Related Group (DRG) fee revenue has increased by 10%. When taking these measures together, the average increase in the per-admission DRG revenue is 14%. We also note that with effect from April 1, 2014, the BHB applied Medical Severity DRG based billing (or MS-DRG), and this might have had an influence on the increase in the DRG based revenue. The increase in local in-patient utilization cannot be ascribed solely to the increase in DRG revenue. For the admissions in Fiscal 2014 the BHB's DRG related revenue constituted approximately 40% of the total in-patient revenues (similar in Fiscal 2013). Aside from DRG revenue, the majority of other in-patient revenue is derived from per-diem ward based revenue (which applies to long-stay patients).

The cost per-capita and loss ratios for Fiscal 2014 and Fiscal 2013 are tabled below:

Table 3: Cost Per-Capita and Loss Ratio

Fiscal 2014		Fiscal 2013		
Cost Per-Capita	Loss Ratio	Cost Per-Capita	Loss Ratio	Cost Per-Capita Increase
$273	97%	$248	105%	10%

The Fiscal 2014 and Fiscal 2013 loss ratios are based on a Standard Premium Rate of $282.27 and $236.73 respectively. The Standard Premium Rate increased at a faster pace than the total per-capita claim costs (19% for the Standard Premium Rate and 10% for the claims). This has led to an improvement in the loss ratio from 105% to 97%.

The following charts illustrate the variation in the local and overseas costs per-capita by insurer / approved scheme, as well as the comparison to the overall cost-per capita. The omission of data points on the charts is deliberate.

Chart 1 – Local Costs Per-Capita (by Insurer)

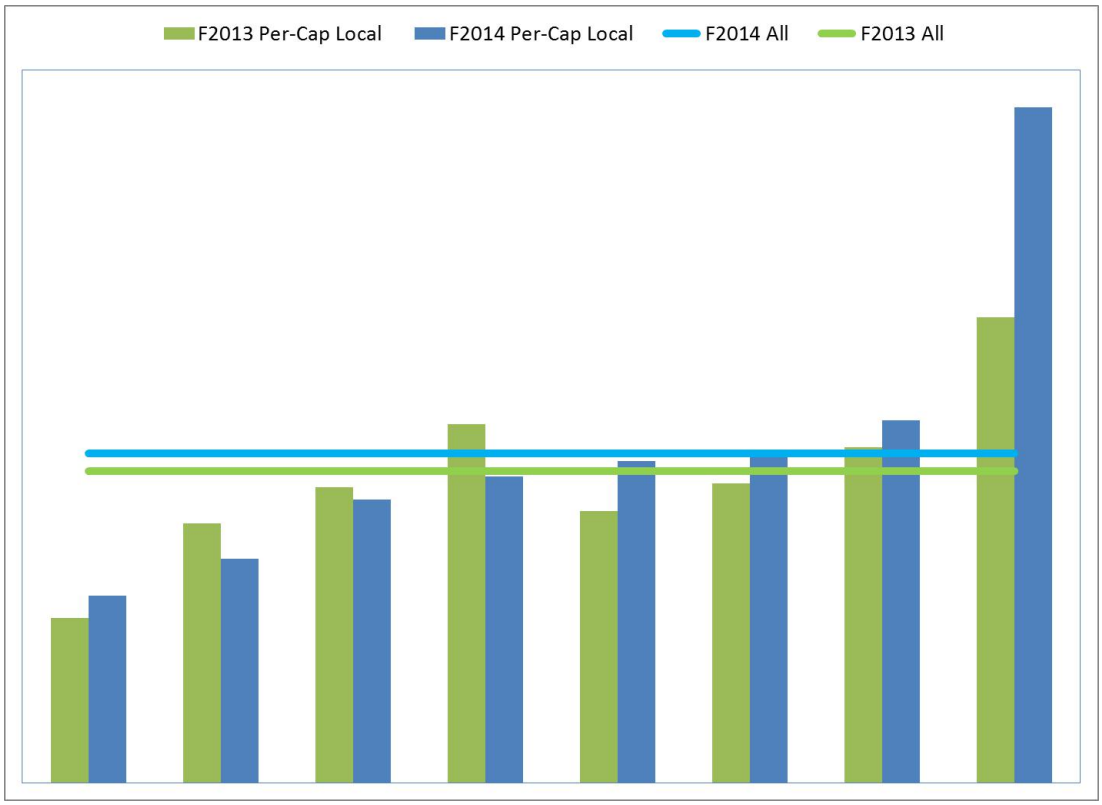
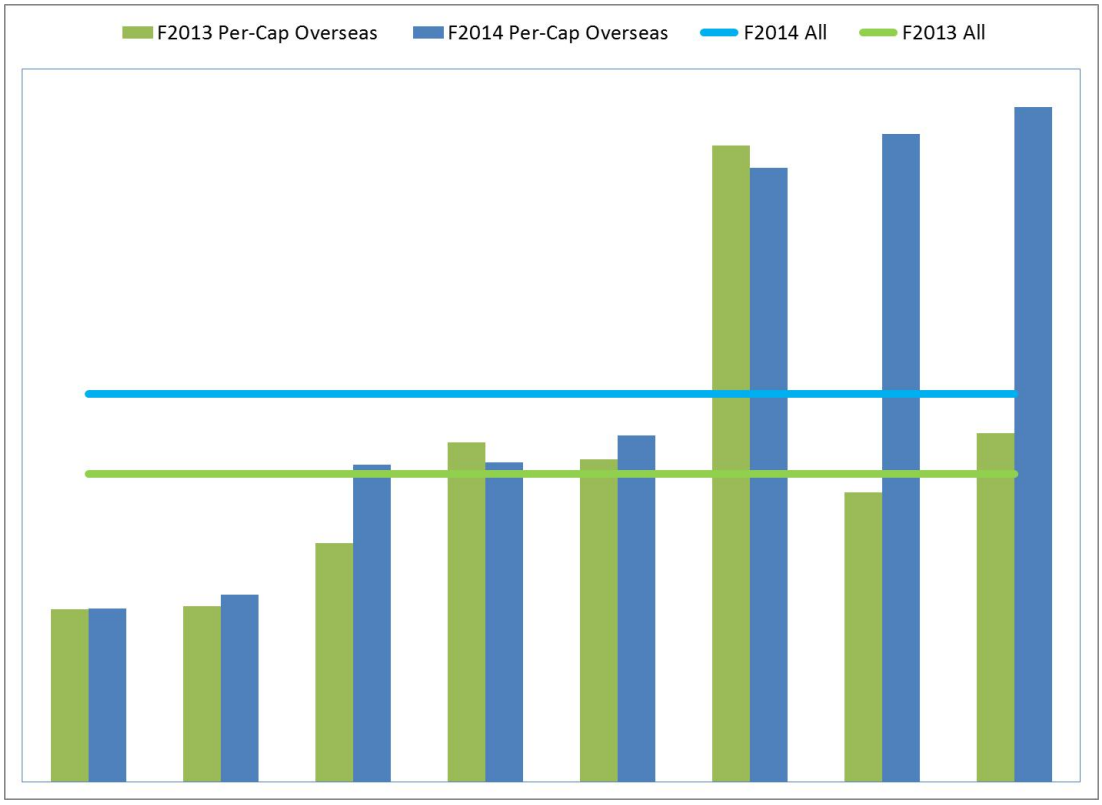


Chart 2 – Overseas Costs Per-Capita (by Insurer)



Since 2009, the data supplied by insurers and approved schemes has included claims data grouped into various age bands. Where such data was provided, the data was analyzed and the charts in Appendix 1 present the average per-capita claims by age band. As expected, the charts show an increasing cost per-capita leading up to age 65 (i.e. healthcare costs on average increase with age). At age 65 a decline is expected due to the government subsidy. The following table comments on the local claim trends over Fiscal 2013 to Fiscal 2014:

Table 4: Costs Per-Capita Trends

Claims Per-Capita	Trends Fiscal 2013 to Fiscal 2014 (ages 20-79)
Local In-Patient Claims	2014 mostly shows increases prior to age 40 and a significant increase in the 60 – 64 age band. The age bands beyond 65 show declines and this has been the case for the past 2 years.
Local Out-Patient Claims	This is almost the opposite of the experience under in-patient claims. The younger age bands indicate declines whereas the older age bands show increases.

We have also analyzed In-Patient data supplied by the Bermuda Hospitals Board and In-Patient and Out-Patient data supplied by the insurers. The results of this analysis can be found in Appendix 2 and Appendix 3.

B.3. : The Standard Premium Rate History

The history of the SPR is as follows:

Table 5: SPR and Loss Ratio History

	Standard Premium Rate	% Change	Loss Ratio*
Fiscal 2007	$140.92	17.9%	93%
Fiscal 2008	$152.59	8.3%	100%
Fiscal 2009	$164.37	7.7%	109%
Fiscal 2010	$184.01	11.9%	112%
Fiscal 2011	$209.63	13.9%	108%
Fiscal 2012	$225.46	7.6%	106% (revised)
Fiscal 2013	$236.73	5.0%	105%
Fiscal 2014	$282.27	19.2%	97%
Fiscal 2015	$272.67	(3.4%)	To be determined next year

* based on a comparison of the SPR to the determined claims cost per-capita

B.5. : The Standard Premium Rate Recommendation

The recommendation for the Fiscal 2016 Standard Premium Rate is as follows:

Table 6: SPR Recommendation

	Increase %	
Fiscal 2015 SPR		$272.67
1. Increase in BHB Fees (adjustment to Fee Schedule)	1.00%	$2.73
2. Allowance for Change in Local Utilization / Inflation / Services	0.00%	$0.00
3. Changes in Benefit Provisions		
a) Inclusion of BHB schedules 3B and 4B	1.3%	$3.46
b) Increase in emergency ambulance fees	0.2%	$0.63
c) Increase in artificial limb coverage	0.3%	$0.80
d) Reduced costs for long-stay patients	(2.0%)	($5.46)
e) Reduced costs in respect of mammography	(0.2%)	($0.50)
Recommended Fiscal 2016 SPR		**$274.33**
% Change in SPR		**0.6%**
$ Change in SPR		**$1.66**

Notes

1. The increase in the BHB fees is based on direction provided by the Ministry of Health, Seniors and Environment. The BHB fee schedule is to increase by 1%.
2. Over the three year period ending in Fiscal 2014, the average increase in utilization has been 5% - 6% per annum. Our prospective assumption is that utilization over Fiscal 2016 will be approximately 5% per annum. Based on direction provided by the Ministry (which we understand is informed by the most recent claims experience observed in the government subsidy plan), no allowance for increased utilization is assumed in the calculation of the Fiscal 2016 SPR. If increased utilization were to materialize, the Fiscal 2016 loss ratio will be higher than would otherwise have been the case.

3. We understand that with effect from Fiscal Year 2016 various changes will be effected. These are:
    a) The SHB coverage will expand to include the fees listed under the BHB Schedules 3B and 4B.
    b) The BHB fees for emergency ambulance services will increase to provide additional necessary coverage to the Island.
    c) The lifetime maximum limit under the SHB in respect of artificial limb coverage is to increase from $15,000 to $30,000.
    d) It is anticipated that certain long-stay BHB patients will be discharged and they will receive care in an alternate setting (such as in a residential or home-care settings).
    e) Utilization of mammography services is expected to decline.
4. We recommend maintaining the multiplier at 4 times the SPR for those over age 65 and not eligible for the government subsidy (to be eligible for the government subsidy one has to have been resident for a continuous period of not less than 10 years during the period of 20 years immediately preceding the application for payment of the subsidy). The cost (without subsidies) for persons aged 65 and over is estimated to be approximately four times the population as a whole (and the SPR is representative of the cost of the population as a whole).

Section C – Mutual Reinsurance Fund

C.1. : Introduction

The Mutual Reinsurance Fund (MRF) is funded by a premium which is added onto each health insurance contract. The insurance providers collect a premium from each insured participant and deposit this premium with the MRF. The determination of the premium rate of the MRF rests with the Ministry of Health, Seniors and Environment, under advisement of the Bermuda Health Council.

The MRF serves the following purposes:

a) it acts as a catastrophic fund[2] to cover certain high dollar value claims which are included as benefits under the SHB,

b) it allows the introduction and assessment of new and experimental treatments and programs which have no prior established actuarial experience or pricing model,

c) it transfers funds to the following:

- the Health Insurance Department of the Ministry of Health, Seniors and Environment (due to HID's role as insurer of last resort with their acceptance of high-cost participants and open enrollment policies which impose no terms of underwriting or exclusion of pre-existing conditions),
- the Health Council so that it may continue to fulfill its mandate as it relates to the oversight of insurers, healthcare providers, the SHB, MRF and other initiatives, and
- with effect from Fiscal 2016, to the BHB to sustain the operations of the hospital.

[2] For the period prior to April 1, 2014.

The SHB procedures that were paid (prior to Fiscal 2015) from the MRF are as follows:

1) Haemodialysis
2) Kidney Transplant (up to $30,000)
3) Anti-rejection drugs
4) Long-term stay (in hospital)
5) Home Health care (up to March 31, 2011)

C.2. : Claims and Financial Information

A history of claims under the MRF is as follows:

Table 7: Claims History

Fiscal Year	Claims Paid	% Change
2009	$11,577,000	14%
2010	$15,744,000	36%
2011	$15,859,000	1%
2012	$17,137,000	8%
2013	$18,438,000	8%
2014	$20,659,000	12%

The history of the MRF Premium is as follows:

Table 8: Premium History

	MRF Premium Rate	% Change
Fiscal 2009	$22.84	7.5%
Fiscal 2010	$24.43	7.0%
Fiscal 2011	$26.51	8.5%
Fiscal 2012	$26.81	1.1%
Fiscal 2013	$34.88	30.1%
Fiscal 2014	$43.57	24.9%
Fiscal 2015	$29.18[3]	(33.0%)

[3] From Fiscal 2015, all MRF coverages were transferred to the SHB and became payable by the insurers. This results in a decline in the MRF premium.

C.3. : The Mutual Reinsurance Fund Premium Recommendation

The recommendation for the Fiscal 2016 MRF Premium is as follows:

Table 9: MRF Recommendation

		Increase %	
Fiscal 2015 MRF Premium			$29.18
1.	Funding of a Pilot Primary Care Program	21.2%	$6.19
2.	Transfers		
	a) Increase transfer to Health Council	1.1%	$0.33
	b) Increase transfer to HID	15.1%	$4.40
	c) Initiate a transfer to the BHB	81.0%	$23.64
Recommended Fiscal 2016 MRF Premium			**$63.74**
% Change in MRF Premium			**118.4%**
$ Change in MRF Premium			**$34.56**

Notes

1. In Fiscal 2016, a pilot primary care program will commence for uninsured, indigent persons with predefined chronic non-communicable diseases. HIP's Financial Assistance clients will also be included. Those eligible under the program will receive primary care support, relevant diagnostics, and condition-specific prescription drugs.
2. With respect to the transfers:
   a) The transfer to the Health Council will increase by $0.33.
   b) As a result of the additional risk and claims that are absorbed by the Health Insurance Plan[4], the transfer to HIP will increase by $4.40.

[4] HIP acts as an insurer of last resort with open enrollment policies that lead to the attraction of high-cost participants.

c) A transfer to the BHB will commence. The transfer represents the following:

- A change in the provisions of the SHB to cover the cost of an in-patient stay in the Acute Care Wing at the semi-private ward rate. At present the SHB covers the stay at the general ward rate. This gives rise to a transfer of $7.24 per month for each insured person.
- An increase in the Standard Dollar Amount[5] from $7,113 to $8,533. This translates approximately into the equivalent of a 20% increase in the MS-DRG fees and gives rise to a transfer of $16.40 per month for each insured person.
- The transfer from the MRF includes the government subsidy that would be payable on each of the abovementioned items.

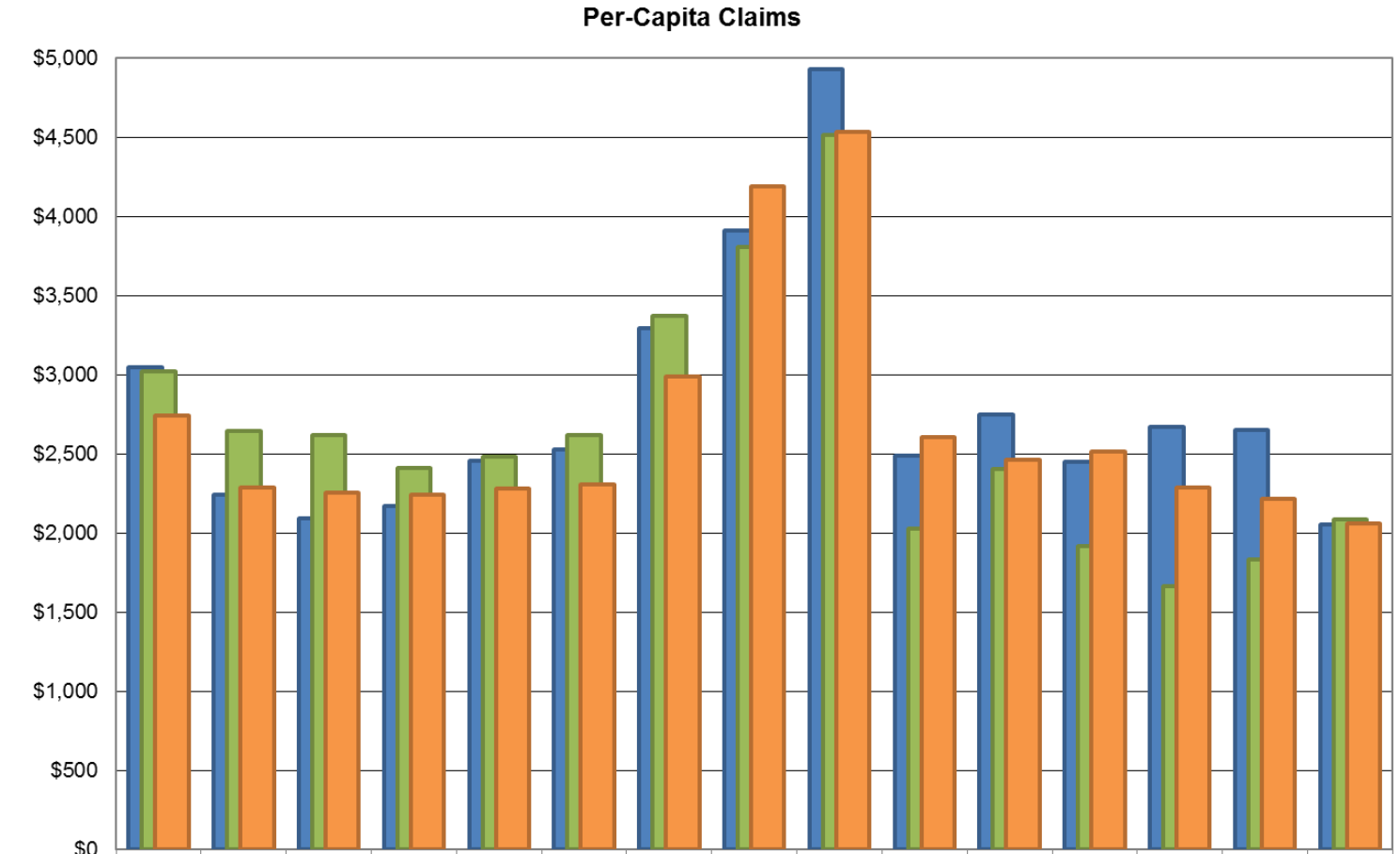
3. The Fiscal 2016 MRF funding allocations are summarized as follows:

Table 10 – Fiscal 2016 MRF Funding Allocations

	Funding Allocation (per month per member)
FutureCare	$14.00
Health Insurance Plan	$18.40
Bermuda Health Council	$1.00
Pilot Primary Care Program	$6.19
Bermuda Hospitals Board	$23.64
Operational and Administrative	$0.51
Total	**$63.74**

[5] The Standard Dollar Amount is applied to the relative value units under the MS-DRGs to determine the fee.

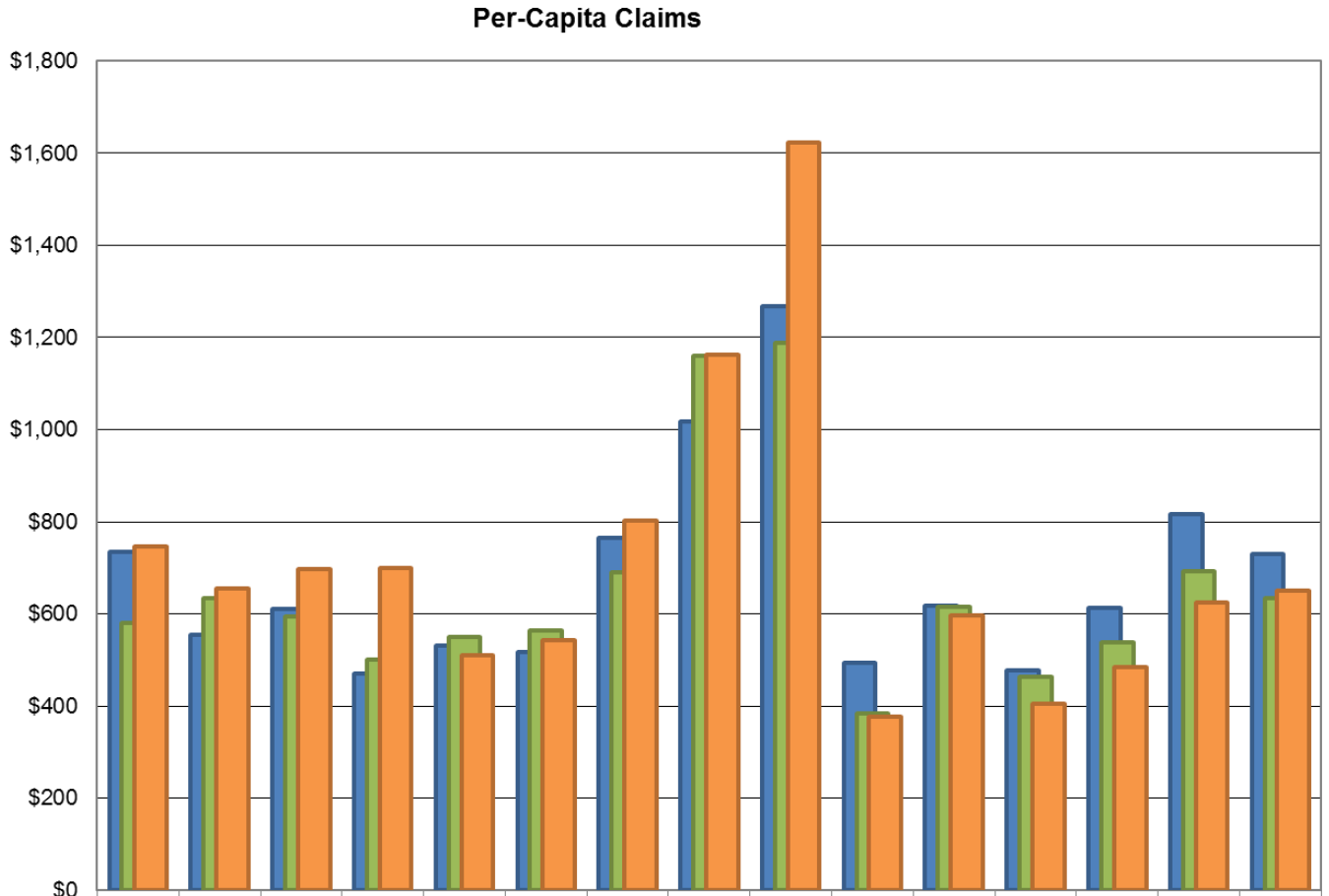
Appendix 1 – Standard Hospital Benefits (Total Annual Per-Capita Claim Costs)



	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
2012 Total	$3,047	$2,240	$2,094	$2,168	$2,455	$2,527	$3,293	$3,910	$4,932	$2,488	$2,749	$2,447	$2,673	$2,648	$2,054
2013 Total	$3,024	$2,643	$2,621	$2,413	$2,480	$2,618	$3,370	$3,808	$4,512	$2,027	$2,407	$1,918	$1,661	$1,836	$2,084
2014 Total	$2,744	$2,286	$2,258	$2,244	$2,281	$2,304	$2,988	$4,191	$4,533	$2,607	$2,463	$2,513	$2,287	$2,218	$2,058

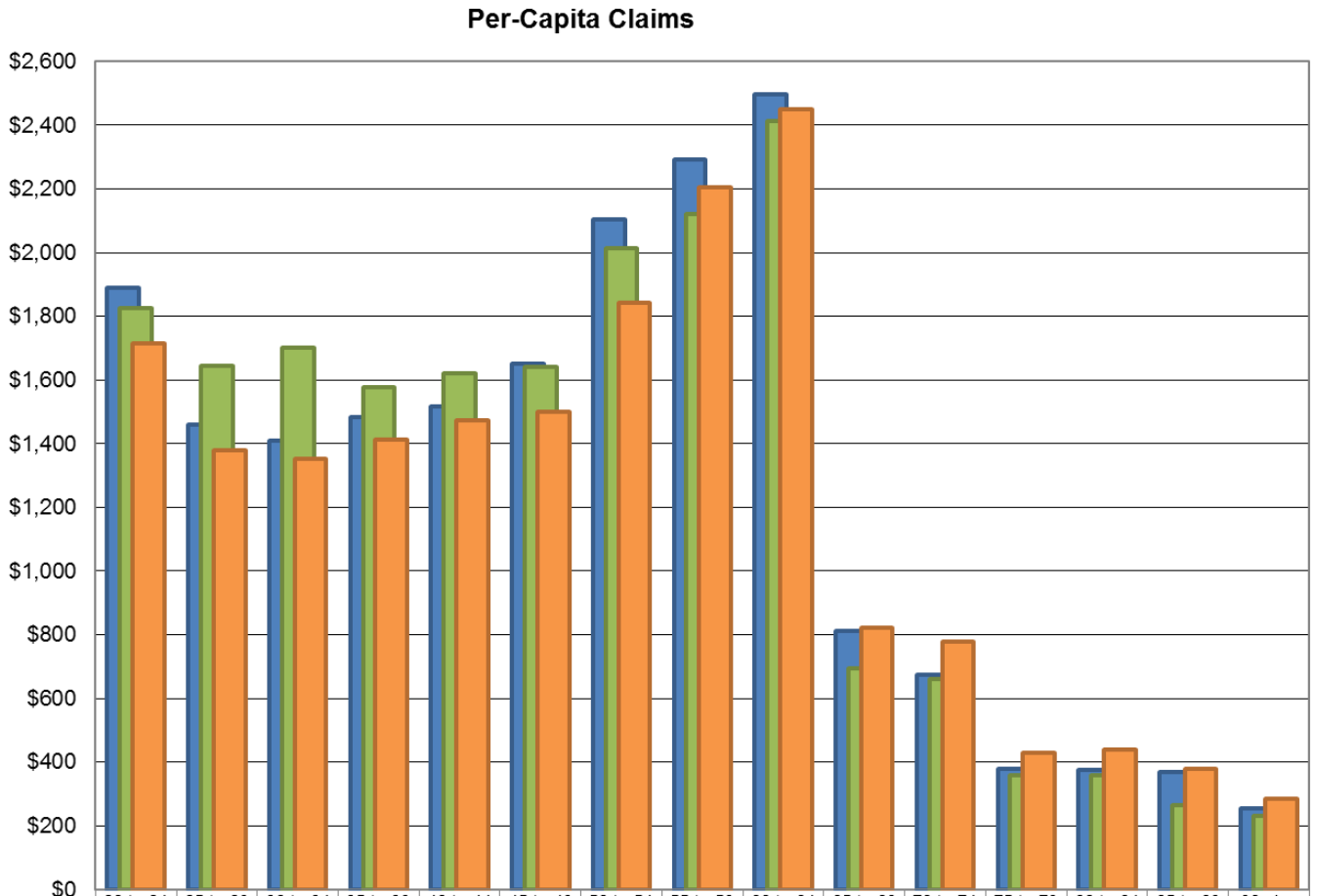
The decline in the cost per-capita at age 65 is due to the government subsidy.

Appendix 1a – Standard Hospital Benefits (Bermuda In-Patient Annual Per-Capita Claim Costs)



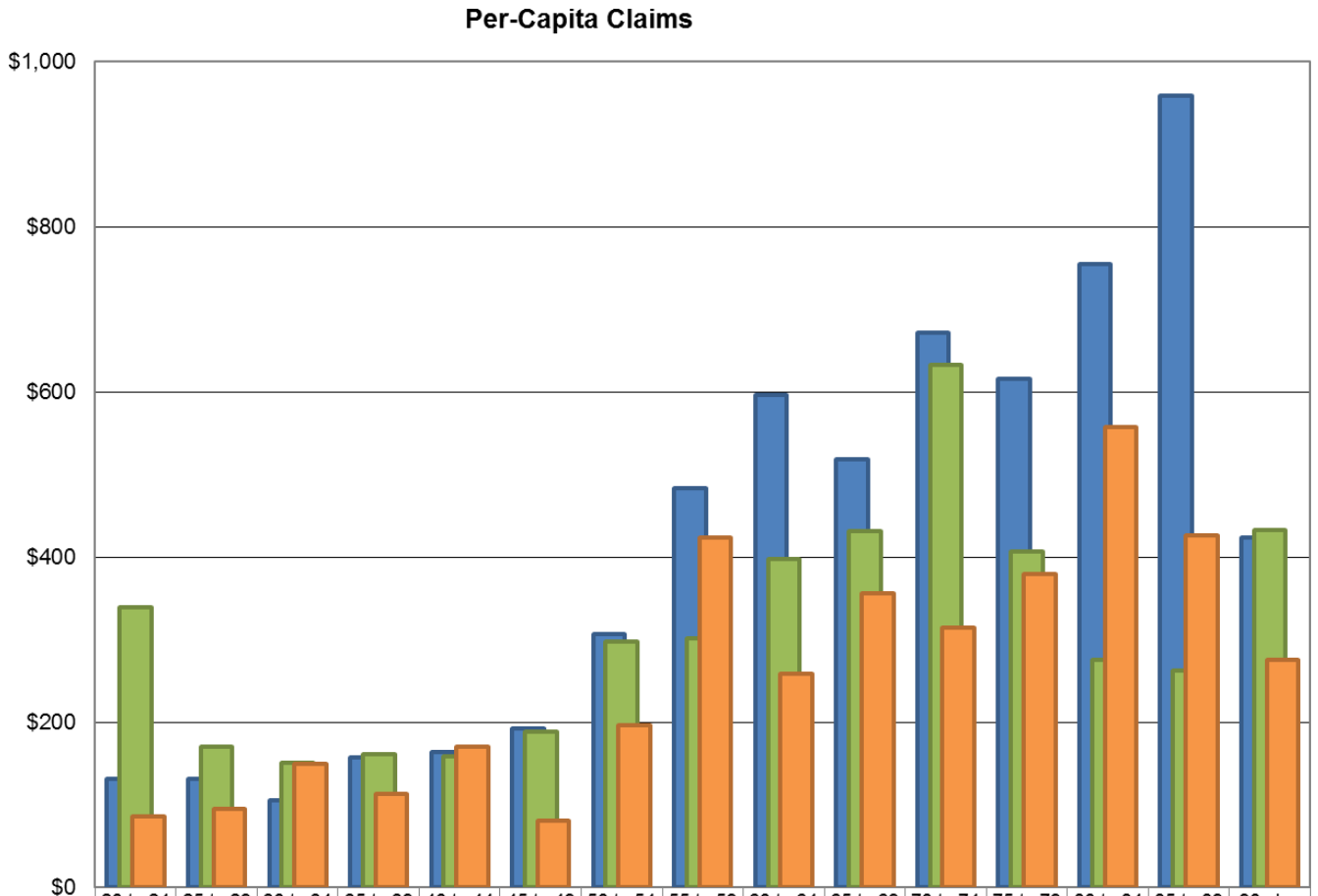
	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
2012 Bermuda Inpatient	$735	$554	$612	$470	$530	$518	$764	$1,018	$1,267	$495	$618	$478	$614	$816	$729
2013 Bermuda Inpatient	$580	$634	$594	$501	$549	$565	$689	$1,161	$1,189	$383	$614	$463	$537	$693	$634
2014 Bermuda Inpatient	$747	$654	$696	$700	$509	$542	$802	$1,163	$1,624	$376	$597	$405	$484	$625	$650

Appendix 1b – Standard Hospital Benefits (Bermuda Out-Patient Annual Per-Capita Claim Costs)



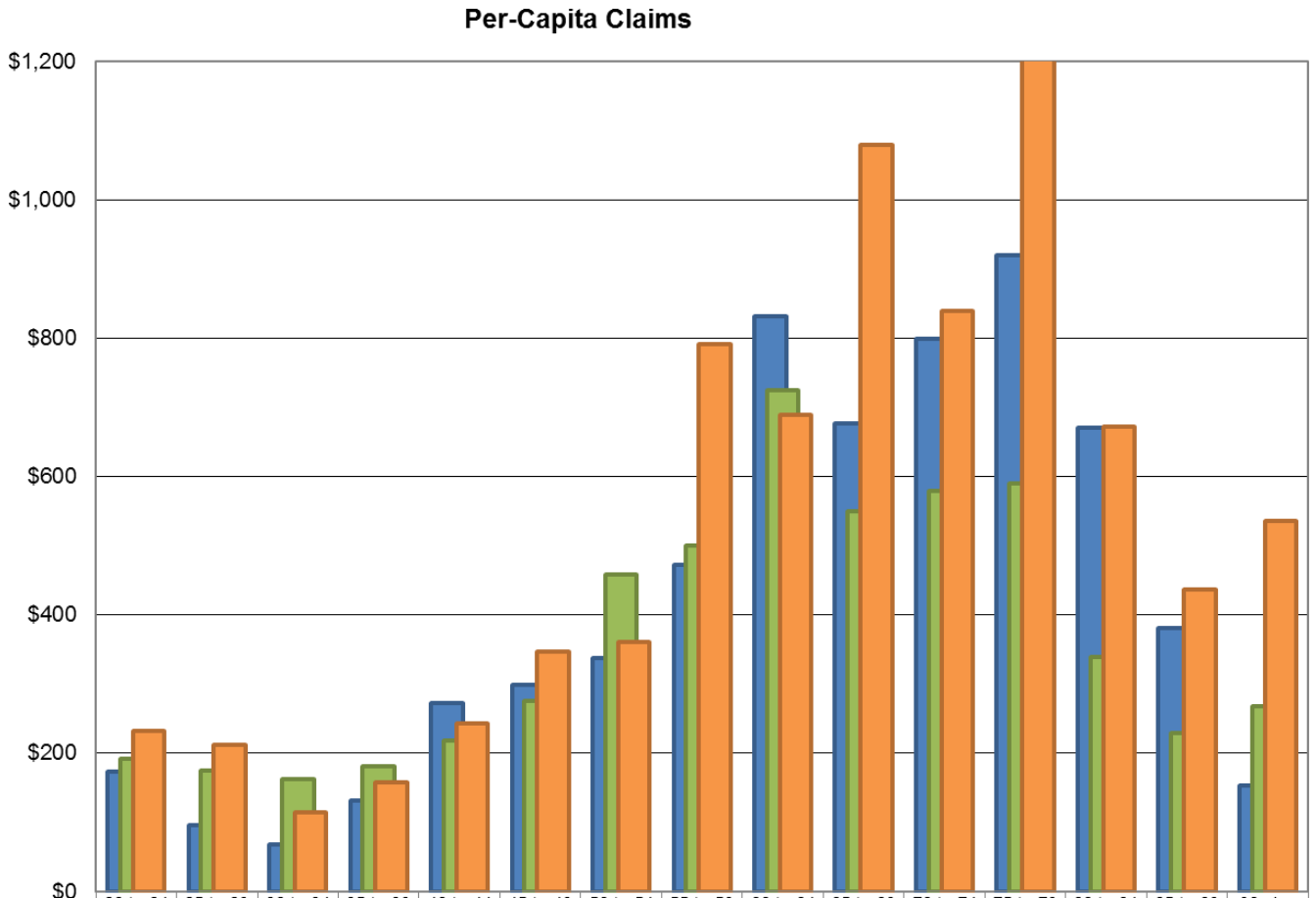
	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
2012 Bermuda Outpatient	$1,891	$1,458	$1,409	$1,484	$1,518	$1,650	$2,103	$2,294	$2,498	$813	$676	$378	$375	$369	$254
2013 Bermuda Outpatient	$1,826	$1,643	$1,700	$1,576	$1,620	$1,643	$2,013	$2,123	$2,414	$694	$659	$358	$360	$265	$232
2014 Bermuda Outpatient	$1,716	$1,379	$1,354	$1,414	$1,473	$1,499	$1,843	$2,206	$2,451	$820	$777	$429	$438	$380	$283

Appendix 1c – Standard Hospital Benefits (Overseas In-Patient Annual Per-Capita Claim Costs)



	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
2012 Overseas Inpatient	$131	$131	$105	$157	$164	$192	$306	$483	$597	$519	$671	$615	$755	$959	$423
2013 Overseas Inpatient	$339	$171	$151	$161	$158	$189	$297	$301	$397	$432	$633	$406	$276	$262	$433
2014 Overseas Inpatient	$86	$95	$150	$113	$171	$81	$196	$424	$258	$356	$314	$380	$557	$426	$276

Appendix 1d – Standard Hospital Benefits (Overseas Out-Patient Annual Per-Capita Claim Costs)



	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 plus
2012 Overseas Outpatient	$174	$96	$68	$132	$272	$298	$337	$472	$832	$677	$800	$920	$671	$380	$153
2013 Overseas Outpatient	$192	$175	$163	$180	$218	$275	$459	$500	$725	$551	$580	$590	$338	$229	$267
2014 Overseas Outpatient	$232	$212	$115	$158	$243	$347	$361	$791	$689	$1,080	$839	$1,204	$672	$437	$535

Appendix 2 – Bermuda Hospitals Board In-Patient Analysis - Admissions by Age

	Fiscal 2014				Fiscal 2013			
Age	Number of Admissions	Total DRG Fee (in '000)	% of Admissions	% of Total Cost	Number of Admissions	Total DRG Fee (in '000)	% of Admissions	% of Total Cost
<5	876	$5,012	15%	10%	964	$4,825	16%	11%
5-14	141	$876	2%	2%	155	$716	3%	2%
15-24	311	$2,483	5%	5%	336	$2,030	5%	5%
25-34	721	$4,870	12%	10%	794	$4,239	13%	10%
35-44	612	$4,628	10%	9%	648	$4,323	11%	10%
45-54	614	$5,746	10%	12%	640	$5,260	10%	12%
55-64	773	$7,777	13%	16%	727	$6,764	12%	15%
65-74	712	$7,094	12%	14%	752	$6,875	12%	15%
75-84	698	$6,746	12%	14%	724	$6,318	12%	14%
85-95	397	$3,528	7%	7%	359	$3,048	6%	7%
>95	28	$260	0%	1%	13	$116	0%	0%
Total	5,883	$49,019	100%	100%	6,112	$44,514	100%	100%

Data Source : BHB

Notes

1. The total fees are the DRG charge only (prior to subsidy) and do not include the per-diem fee or any other fee charged for in-patient services.
2. The number of admissions in Fiscal 2014 has declined by 3.7%.
3. The under 5 age group is mostly comprised of newborns.
4. The percentage of cost related to those age 65 and over is 36% in Fiscal 2014 (which is similar to Fiscal 2013).
5. In Fiscal 2014 the increase in total cost for admissions under age 65 is 11% and 8% for those age 65 and over.

Appendix 2a - Admissions by Major Diagnostic Categories

	Fiscal 2014				Fiscal 2013		
Major Diagnostic Category (sorted by F2014 Fee)	**Number of Admissions**	**Change in Admissions**	**Total DRG Fee (in '000)**	**% of Total Cost**	**Number of Admissions**	**Total DRG Fee (in '000)**	**% of Total Cost**
Musculoskeletal System And Connective Tissue	774	10%	$9,241	19%	705	$7,145	16%
Digestive System	545	-3%	$5,616	11%	562	$5,374	13%
Circulatory System	682	12%	$5,486	11%	610	$4,436	10%
Respiratory System	533	-10%	$4,308	9%	592	$4,073	9%
Pregnancy, Childbirth and Puerperium	732	-8%	$3,695	8%	795	$2,779	6%
Newborn And Other Neonates (Perinatal Period)	640	-8%	$3,616	7%	698	$3,604	8%
Nervous System	364	-9%	$2,892	6%	401	$3,294	7%
Kidney And Urinary Tract	235	-12%	$1,809	4%	266	$1,866	4%
Infectious and Parasitic DDs	137	-18%	$1,720	4%	168	$2,246	4%
Hepatobiliary System And Pancreas	183	-8%	$1,686	3%	199	$1,679	3%
Skin, Subcutaneous Tissue And Breast	189	8%	$1,468	3%	175	$1,241	3%
Ear, Nose, Mouth And Throat	179	-18%	$1,225	2%	217	$954	3%
Endocrine, Nutritional And Metabolic System	171	4%	$1,124	2%	165	$952	2%
Not Classified	39	8%	$1,025	2%	36	$905	2%
Female Reproductive System	105	-27%	$783	2%	144	$888	2%
Blood and Related	100	-14%	$746	2%	116	$708	2%
All Other	275	5%	$2,580	5%	263	$2,368	5%
Total	**5,883**	**-4%**	**$49,019**	**100%**	**6,112**	**$44,513**	**100%**
Change over Year	**-4%**		**10%**		**15%**	**12%**	

Data Source : BHB

Notes: 1. We have summarized the DRG codes into mutually exclusive diagnosis areas (referred to as Major Diagnostic Categories).

2. The average DRG charge per admission increased by 14%. In Fiscal 2014, the MS-DRG coding took effect.

Appendix 2b - Fiscal 2014 Admissions, Days in Hospital

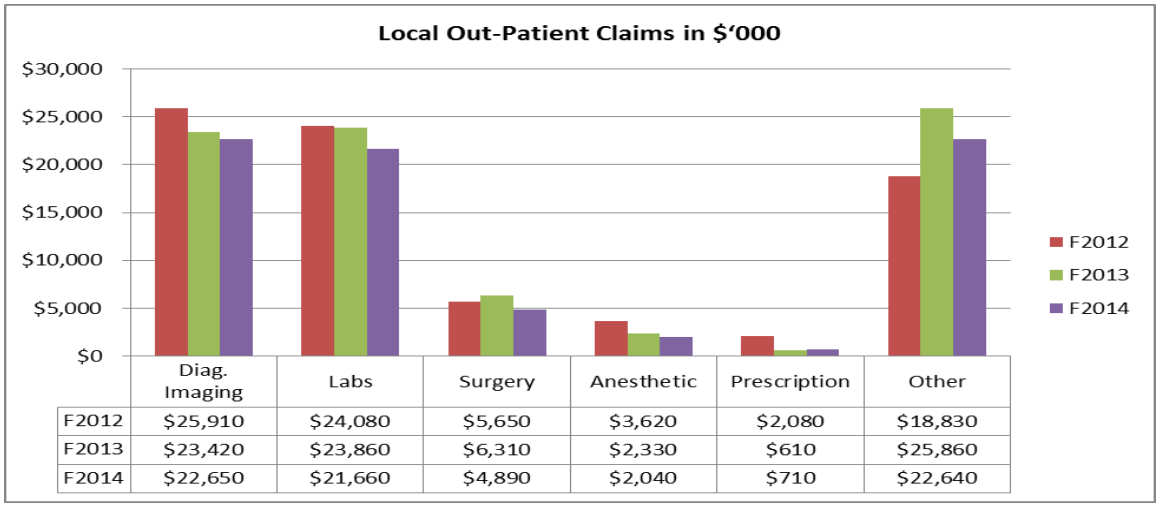
Days in Hospital	Number of Admissions	% of Admissions	% of Total Cost	Average days in Hospital	DRG Fees (in '000)
0-4	3,851	65%	54%	2.1	$26,324
5-9	1,202	20%	24%	5.8	$11,985
10-14	346	6%	8%	10.7	$3,888
15-19	156	3%	4%	15.0	$1,951
20-24	86	1%	2%	20.0	$1,179
25-29	61	1%	2%	21.8	$965
30-35	44	1%	1%	30.8	$669
>35	136	2%	4%	61.2	$2,050
	5,882	100%	100%	5.7	$49,012

Data Source : BHB

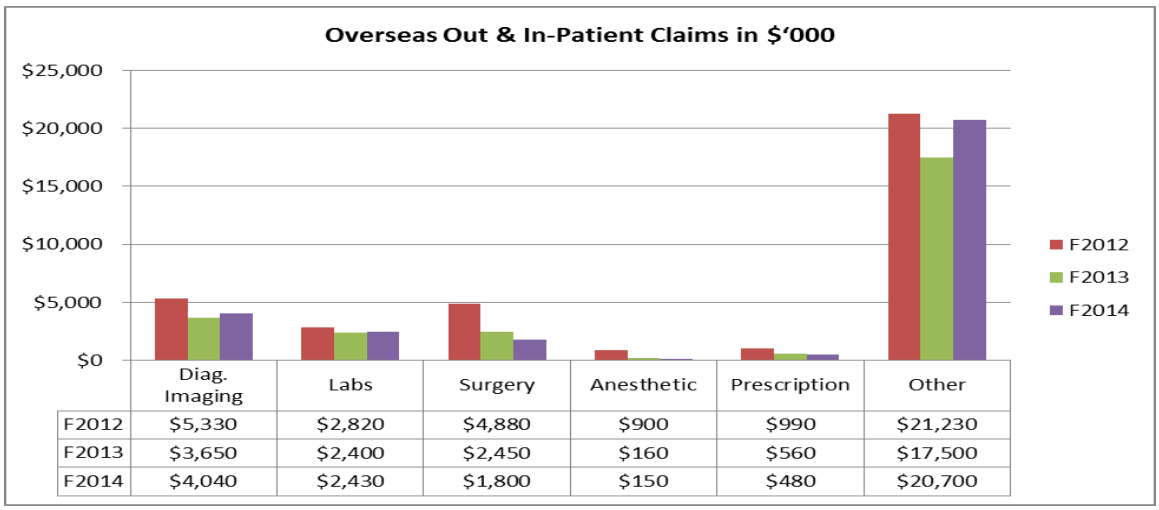
Notes

1. Eighty-five percent of admissions are under 10 days, which is similar to prior fiscal periods.
2. For Fiscal 2014 admissions, the average days in hospital has declined to 5.7 days. For Fiscal 2013 admissions, it was 6.4 days and for Fiscal 2012 admissions it was 6.7 days.

Appendix 3 – Split of Local Out-Patient data and Overseas In-Patient and Out-Patient data



	Diag. Imaging	Labs	Surgery	Anesthetic	Prescription	Other
F2012	$25,910	$24,080	$5,650	$3,620	$2,080	$18,830
F2013	$23,420	$23,860	$6,310	$2,330	$610	$25,860
F2014	$22,650	$21,660	$4,890	$2,040	$710	$22,640



	Diag. Imaging	Labs	Surgery	Anesthetic	Prescription	Other
F2012	$5,330	$2,820	$4,880	$900	$990	$21,230
F2013	$3,650	$2,400	$2,450	$160	$560	$17,500
F2014	$4,040	$2,430	$1,800	$150	$480	$20,700

Data Source : Insurers

Notes

1. Locally, all categories except for "other" have declined since Fiscal 2012. The "other" category has declined significantly since Fiscal 2013. Local Diagnostics and Labs constitute 59% of Fiscal 2014 local out-patient spending. The category other contains 30% of the Fiscal 2014 local out-patient spending.
2. In the local context, the other category is in respect of all other services (e.g. emergency room services, oncology and cardiology services).

The data for the charts above can be found in the tables below.

Appendix 3a – Table of Local Out-Patient data and Overseas In-Patient and Out-Patient data

Claims in $'000	1. Diag. Imaging (outpatient)	2. Diag. Imaging (appr.facility)	3. Labs	4. Surgery	5. Anesthetic	6. Prescription	7. Other outpatient claims	Total
Local Out-Patient Claims F2012	$18,600	$7,310	$24,080	$5,650	$3,620	$2,080	$18,830	$80,170
Local Out-Patient Claims F2013	$16,850	$6,570	$23,860	$6,310	$2,330	$610	$25,860	$82,400
Local Out-Patient Claims F2014	$16,280	$6,370	$21,660	$4,890	$2,040	$710	$22,640	$74,590
Overseas Out & In-Patient Claims F2012	$5,330		$2,820	$4,880	$900	$990	$21,230	$36,140
Overseas Out & In-Patient Claims F2013	$3,650		$2,400	$2,450	$160	$560	$17,500	$26,720
Overseas Out & In-Patient Claims F2014	$4,040		$2,430	$1,800	$150	$480	$20,700	$29,610
Total Claims F2012	$31,240		$26,900	$10,530	$4,520	$3,070	$40,060	$116,310
Total Claims F2013	$27,070		$26,260	$8,760	$2,490	$1,170	$43,360	$109,120
Total Claims F2014	$26,690		$24,090	$6,690	$2,190	$1,190	$43,340	$104,200
Total % Increase F2012 – F2013	-13%		-2%	-17%	-45%	-62%	8%	-6%
Total % Increase F2013 – F2014	-1%		-8%	-24%	-12%	2%	0%	-5%

Data Source : Insurers

About Morneau Shepell

Morneau Shepell is Canada's largest human resource consulting and outsourcing firm focused on pensions, healthcare, and workplace health management and productivity solutions.

We offer consulting and administrative services for the full range of retirement, healthcare, and employee benefits programs, as well as absence and disability management, workplace training and education, and employee assistance program. This suite of services allows us to offer solutions that help improve the financial security, health and productivity of organizations and their people around the globe.

Morneau Shepell has approximately 3,900 employees in 70 locations across Canada, the United States and the Bahamas. We provide services across Canada, the United States, Bermuda, the Caribbean and around the globe. Our clients range from government entities, associations, large corporations and small businesses. The origins of our company trace back to 1962.