cayman islands insurance association

HEALTH INSURANCE STANDING COMMITTEE

GAP ANALYSIS AND REFORM PROPOSAL FOR HEALTHCARE FUNDING IN THE CAYMAN ISLANDS

PART I: Introduction to Identified Gaps in the Cayman Islands Healthcare Funding System

GAP ANALYSIS AND REFORM PROPOSAL FOR HEALTHCARE FUNDING IN THE CAYMAN ISLANDS

INTRODUCTION

THE CIIA

The Cayman Islands Insurance Association ("CIIA") was formed in 2004 to bring together the various associations representing the insurance industry in the Cayman Islands. The intention was to create a single body that can respond to and advise the public on insurance issues and to have a single voice in discussions with the Cayman Islands Monetary Authority, who regulate the insurance industry. The CIIA has a central board elected by its membership as well as three Standing Committees: The General Insurance Standing Committee ("GISC"), the Health Insurance Standing Committee ("HISC") and the Life Insurance Standing Committee ("LISC").

THE HISC

This document has been created by the Health Insurance Standing Committee of the CIIA. The HISC has a varied membership of insurance carriers, insurance agents, and insurance brokers active in the Health Insurance Market in the Cayman Islands. The main difference in these members is what their role is in the market and the interests that they naturally represent. Insurance carriers representing the interests of all aspects of their portfolios, agents representing the interests of carriers, and brokers representing the interests of the insurance client. The HISC also comprises long standing Caymanian members of the Cayman Islands insurance community bringing an extensive understanding of Cayman healthcare and newer additions to this market who have come from other parts of the world who bring with them experiences of healthcare systems that work in different ways. This diversity of perspective leads to a very rounded and robust discussion of the issues presented in this document.

THE HISC WORKING GROUP

In June 2019 the HISC established a Working Group in response to the national call for healthcare reform. It was determined that with the years of experience and the data that each member of the HISC has extensive access to, the HISC would be in a unique position to present a view of the gaps in the current healthcare environment and infrastructure, the impact of these gaps, and propose next steps and options for the future benefit of the Cayman Islands.

GAP ANALYSIS AND REFORM PROPOSAL FOR HEALTHCARE FUNDING IN THE CAYMAN ISLANDS

THE SCOPE OF THIS DOCUMENT

By creating this document, the HISC intends to open the discussion about the parts of the public-private healthcare system that could be improved. In recent years the national discussion has centered around the debate on changing the system entirely to a national healthcare single-payor system to address the rising cost of healthcare borne by the public sector. The HISC takes the position that the rising cost of healthcare will not be addressed by changing who pays for healthcare, but rather that there are gaps in the current system and that closing these gaps could have a greater impact on the rising cost of healthcare than a wholesale change to a different system. The gaps in the current system have resulted in high costs, risks to public safety and in some instances, insufficient levels of cover for patients accessing care in the Cayman Islands.

In creating this document, the HISC aims to provide both long and short term recommendations in line with both long and short term goals for healthcare in the Cayman Islands by being innovative and learning from the experiences of other countries. This document will first provide an overview of how the current healthcare environment is structured and how each of the stakeholders function before going on to identify and explore gaps and solutions. It is intended that by producing this document, the members of the HISC will initiate a transparent partnership with the public and other stakeholders in creating a well-informed, apolitical healthcare agenda that serves the needs of all for today and into the future. If the recommendations made here are received, acknowledged, and considered in the decisions for change that are being made, the HISC will have considered our efforts to be a success.

This document will be split into four parts. This part will serve as an introduction to the system that is currently in place and the subsequent three parts will cover three categories under which we have identified gaps. These categories are as follows.

PART II - Healthcare and Funding Gaps for Vulnerable Populations

We acknowledge and cover as our first priority groups of people who are most vulnerable to being underserved in our current system, either by diagnosis or by socio-economic position. The topics to be covered in Part II include the following:

- Mental Health Care and Coverage
  - Mental health care not sufficiently defined
  - Mental health care not treated as any other illness
- Retirees and Elderly Care and Coverage
- Public Covered Populations – Seamen, Indigent, Civil Service
- Neonates and Newborns with Congenital Defects
- Dependents after death of Primary Insured

PART III - Health Insurance Infrastructure Gaps

There are parts of the current regulatory framework that are either outdated, under maintained, or defunct. These are resulting in glitches and malfunctions in the current system of healthcare funding. The topics to be covered in Part III include the following:

- Missing Categories of Codes for Standard Health Insurance Fees ("SHIF")
  - Dental
  - Vision
  - Mental Health
  - Tertiary Care
  - Pharmacy
- Irregular Review of SHIF
- Irregular Review of Standard Health Insurance Contract ("SHIC") Standard Premium Rates

PART IV - Healthcare Provider Infrastructure Gaps

There are many significant gaps in the way in which the delivery of healthcare is regulated in the Cayman Islands that we believe to be having a direct effect on the rising cost of healthcare and, as a result, on the rising cost of health insurance. The topics to be covered in Part IV include the following:

- No standards of transparency of billing
- No accountability for complaints
- No induction into Cayman healthcare system required for new healthcare providers
- No quality standards (Public Safety)
- Insufficient due diligence on new providers
- Peer review to regulate conduct of providers
- Healthcare providers do not respond to HIC surveys
- No National Pharmacy Formulary or Guidelines

HOW TO USE THIS DOCUMENT

Each of the gaps the HISC has identified has been categorized, the social and economic impact of the gap explored, and solutions proposed in the remainder of this document. This is in no way a comprehensive review of the healthcare system in the Cayman Islands, but has been created to present the problems and solutions to the issues surrounding healthcare funding from the perspective of the members of the health insurance industry. The conclusions in this document are not intended to be the final answer to what should happen in the area of Healthcare Funding, but the initiation of an ongoing discussion that takes into account the perspective of all stakeholders in this system to come to a conclusion that benefits all. It is our invitation that the reader of this document consider the ideas presented as an introduction to one perspective, to be reviewed with an open mind intended to inform and inspire the readers own creative contribution to the national discussion.

THE CAYMAN ISLANDS HEALTHCARE FUNDING SYSTEM

THE DILEMMA OF HEALTHCARE FUNDING

Countries all over the world have been debating the fundamental questions that have, in some variation, haunted healthcare since the times of Ancient Greece. Is healthcare a human right? Or is healthcare a commodity? Is it ethical to receive profit for the provision of healthcare treatment? These questions are not easy to answer, particularly in light of the years of hard work that it takes for a provider of medical care to qualify to work in the provision of healthcare, the funding that is required for research and development for life saving equipment and drugs, and the high standards of quality of care that are required for the provision of healthcare in a way that does not put the life and limb of the patient at greater risk. Healthcare economics are incredibly tricky with a finite supply of knowledge and materials struggling to keep up with the bottomless demand for comfort, care and life saving treatment. In a world where everything is being converted and quantified into money, and where the provision of healthcare comes at a cost, many countries have worked hard to create a balance between the public and private provision of healthcare.

The Cayman Islands is one country that has created a legal framework designed to share the responsibility for the cost of healthcare between the private and the public sector. However, as well considered and well designed as the system is, it is not immune to the questions that plague healthcare systems all over the world. There are various beliefs around healthcare that show up in the debate about what to do about healthcare even here in Cayman. Some parties considering it to be immoral that providers of healthcare and of healthcare funding should make a profit for their work with no regard to the practicalities and cost of the provision of said care, and others considering healthcare to be purely a market sector to be governed by financial rules. These debates have resulted in various changes in the healthcare system in the Cayman Islands over the past 30 years. In and prior to the 1980s, healthcare was provided publicly 'for free' to the people of the Cayman Islands from public funds. In 1985, healthcare that was available in the islands were very limited, the cost of living was relatively low, and the population was a manageable 19,313. By 1995, the population had grown to 31,672, with various guest workers joining the work force, and the Cayman Islands Government came to a practical decision that if the Cayman Islands economy was to continue to grow, a change needed to be made to how healthcare was being provided and paid for. One of these changes came into force in 1998 with the passing of the "Health Insurance Law 1997", requiring employers to take financial responsibility for the health of their employees and their families.

The system of healthcare coverage that exists today has evolved with various revisions of the legal framework, the most recent and comprehensive being the overhaul of the Health Insurance Law and Regulations which came into effect on the 1st of February 2013.

THE CURRENT SYSTEM IN THE CAYMAN ISLANDS FOR HEALTHCARE FUNDING

The Health Insurance Law (2018), Health Insurance Regulations (2017) and Health Insurance Commission Law (2016) together create the following structure for healthcare funding in the Cayman Islands:

1. Approved Insurers – Who can offer cover

Health Insurers offering healthcare coverage in the Cayman Islands have to be approved by the Health Insurance Commission ("HIC") before they can issue a contract for health insurance cover in the Cayman Islands. The Health Insurance Commission reviews new applications and annual applications for renewal in order to issue an Approved Insurer Certificate. Without this, an insurer in the Cayman Islands cannot offer health insurance coverage in the Cayman Islands.

2. The Health Insurance Commission – The responsible regulator

The Health Insurance Commission ("HIC") was created under the Health Insurance Commission Law to be the body regulating the conduct of stakeholders within the structure for healthcare funding. The board of the HIC is made up of the Chief Officer of the Ministry of Health, the Chief Medical Officer, the Superintendent of Health Insurance, and four to six additional appointed members of the public, at least one with a professional background with health insurance and at least one with no connection to the industry at all. The office of the HIC is comprised of the Superintendent of Health Insurance and a number of Health Insurance Inspectors reporting to the Superintendent as well as an Accountant and their office support staff.

The HIC is responsible for the process by which a Health Insurer becomes an Approved Health Insurer permitted to offer health insurance in the Cayman Islands. They are also responsible for collecting the fees that every Approved Health Insurer must pay on a monthly basis into the Segregated Insurance Fund (the "SIF"). Complaints are managed by the office of the HIC and Regulations are created by the Superintendent of Health Insurance. The HIC is also in a good position to provide the Government with information on the Health Insurance industry, as they are in a position to require reports from Health Insurers at their discretion.

The Health Insurance Law and corresponding Regulations give the HIC a very broad spectrum of powers as it relates to the resolution of complaints, collection of data from Approved Health Insurers, enforcement of the rules Health Insurers are required to adhere to, and the power to fine and cease operations of Health Insurers in breach of the rules. These powers of enforcement also extend to the monitoring of the obligations the Health Insurance Law and its corresponding Regulations place on employers and employees. The HIC accepts complaints from the public alleging breaches by employers and insurers and are rigorous in maintaining standards and enforcing the rules in this regard. However, there

are several obligations placed on the Healthcare Provider in the Health Insurance Law and its corresponding Regulations in regards to which the Health Insurance Commission does not have prescribed enforcement powers.

3. Standard Health Insurance Contract ("SHIC") – What coverage can be offered

The Standard Health Insurance Contract is the minimum level of coverage that can and must be offered in the Cayman Islands. The SHIC plan is a prescribed schedule of benefits that forms part of the Health Insurance Regulations. Health insurers may offer benefits above the SHIC plan benefit levels, but cannot offer any benefits below the SHIC plan. The SHIC plan cannot be offered with exclusions and limitations and cannot be refused to applicants who have completed an application form in good faith. Exclusions on richer plans of benefits cannot lower the level of cover below the SHIC benefit level.

4. Standard Health Insurance Fees ("SHIF") – What fees can be covered

When the Cayman Islands first introduced mandatory health insurance, there were no standard fees or Cayman-specific Usual and Customary Rates (UCRs). In the early days of mandatory health insurance, two insurance companies offered plans to the public to meet the new need that were not protected even by company policy UCRs. An insured could buy an insurance plan from one of these companies and their contracts stated that the insurance company would cover 100% of the member's medical bills. What they did not take into account was that a healthcare provider had no limit on what they would charge a patient and that the contract terms put them in a place of great vulnerability. Within a year, both of these companies were bankrupt. Industry lore has it that these companies were brought to their knees by less than five healthcare providers who would charge excessive fees with the guarantee that they would be paid no matter what they charged. Both of those health insurance companies were in no position to question or deny payment on the fees charged.

In order to protect the integrity of the healthcare funding system that appeared to be falling apart right as it was beginning, the Government at the time stepped in and created the Standard Health Insurance Fees. This is now part of the Health Insurance Regulations, and is available to the public on the website of the Department of Health and Regulatory Services in the section designated to the Health Insurance Commission.

The Standard Health Insurance Fees are an extensive list of healthcare services based on the American CPT Code structure. Each service listed has a fee assigned to it. It is this fee that the Health Insurance Provider is required to consider as an eligible expense for the service rendered.

The Standard Health Insurance Fees have been reviewed every couple of years over the past decade. The review, conducted by the Health Insurance Commission, always begins with an invitation to healthcare providers to participate by

providing data from their practices to determine whether these fees are sufficient. Upon review every two or so years, these fees have not been increased, but have been revised to include new codes, and participation in the review by healthcare providers has reportedly been very minimal, as it is voluntary.

It is important to note here that the SHIF is what a Health Insurer is required to acknowledge as an eligible expense. However, the healthcare provider is not required to charge the SHIF and the majority of providers in the private sector choose to charge in excess of these fees rather than participate in the review to increase the fees. The private healthcare provider is free to charge whatever they choose.

5. Segregated Insurance Fund ("SIF") – Contributions to covering the indigent

The Segregated Insurance Fund is a fee levied on all health insurance policies by the Cayman Islands Government. These fees help to fund medical care for indigent residents. All approved Health Insurance companies pay these fees to the Cayman Islands Government through the Health Insurance Commission who are responsible for their collection.

6. Cayman Islands National Insurance Company ("CINICO") – Public Insurer

The Cayman Islands National Insurance Company (CINICO) was established in 2004. The company was formed to facilitate the provision of insurance coverage for civil servants, pensioners, seafarers, veterans and their dependents. CINICO also provides health insurance coverage for some statutory authorities, government companies and administers benefits for indigent residents. At inception, CINICO fell under the responsibility of the Ministry of Health but as of 2013 to date; the company now falls under the Ministry of Finance.

7. Compulsory Health Insurance

The main principle of the Health Insurance Law is that every person resident in the Cayman Islands needs to be covered by no less than the SHIC plan level of coverage. The legal framework also assigns responsibility for this coverage in very specific terms. Every employer in the Cayman Islands is required to effect a contract for a minimum of the SHIC plan for

- Him/herself
- His/her spouse
- His/her dependent children under the age of 18
- His/her financially dependent children up to the age of 30
- His/her medically and/or physically dependent children with no age limit.
- Each of his/her employees, and
- Dependent unemployed spouses, children of his/her employees.

In place of the employer, the Government is assigned responsibility to cover the cost of healthcare for certain groups within the Cayman Islands population. The indigent, Seamen over 55 years of age, their dependents, and widows, and Veterans, their dependents and widows, are among these groups.

As the Government is also an employer, coverage for employees of the Civil Service is the responsibility of the Government as well.

8. Healthcare Provider Obligations

Healthcare Providers are given practical obligations to fulfill in order for the healthcare system to work for the members of the community, their patients. According to the law, Healthcare Providers are required to accept assignment of benefits from the Approved Insurer and seek payment from the Approved Insurer first, taking payment only for the amount not covered by the Approved Insurer from the patient. The law also provides a structure of support for this process, requiring that the Healthcare Provider contact the Approved Insurer in advance of providing the treatment to confirm what benefits the individual has in order for the Healthcare Provider to have some confirmation of what they should be balance billing the patient. How this should work, if everyone in the circumstances fulfill their duties according to the law, is along the following lines:

a. the patient will go the Healthcare Provider for a healthcare service,
b. the Healthcare Provider will request the patient's insurance card which, by law, outlines all the contact detail information that the Healthcare Provider will need to verify benefits,
c. the Healthcare Provider is required to then contact the Approved Insurer for confirmation of what the patient's benefits are,
d. the Healthcare Provider will provide the patient with the healthcare service and is required to bill them only for the amount beyond what the Approved Insurer has confirmed they are covered for,
e. the Healthcare Provider is then required to bill the Approved Insurer for the amount confirmed/verified (above) no later than 180 days after the date of the service with a fully completed claim form prescribed in the Health Insurance Regulations, and finally
f. the Approved Insurer is required to process the claim within 30 working days of receipt of a complete claim, paying to the Healthcare Provider the amount that is covered.

Healthcare providers are also required to report to the Health Insurance Commission the highest fee that they charge for any given service on an annual basis or no later than 30 days after an adjustment has been made in their billing.

9. Health Insurance Consumer Obligations

It is important to note that there are two different types of Health Insurance Consumer. The law prescribes a clear responsibility to every Employer in the Cayman Islands to open a contract of health insurance for each of their employees. The Employer is therefore the client of the Health Insurance Provider. The employees and their dependents are the second Health Insurance Consumer with third party rights under the contract for insurance effected by their employer with the Health Insurance Provider.

Employers are obligated to provide access to insurance cover for all their employees and unemployed dependents, and they are obligated to pay on behalf of their employee only 50% of the premium of the Standard Health Insurance Contract and continue to provide them access to cover (but not contribute to the premium) for 3 months after the end of their employment. An employer who fails to do this is in breach of the law.

Individuals who are not employed by another are treated as both Employer and Employee by the law. The self-employed person is required to provide insurance cover for themselves and their eligible dependents in the same way they would be required to provide cover for their employees.

Every individual who signs up for an insurance plan (employer, employee and dependent) also has obligations under the Health Insurance Law and its corresponding Regulations. They are required to provide full and accurate information in relation to the state of their health on their application forms and required to cover the portion of their health insurance premium that their employer does not cover for themselves and their dependents. To knowingly provide a false statement on an application form or claim form is considered to be fraud and can cause a complete cancellation of their health insurance coverage.

10. Health Insurance Provider Obligations

Health Insurance Providers have multiple obligations under the Insurance Law, the Health Insurance Law and Regulations, and further still at the request of the HIC. The HIC has almost limitless discretion on what data can be requested from a Health Insurer with clear powers of enforcement (fines and summary conviction, etc) should a Health Insurer fail to comply. The broad outline of these obligations are as follows:

a. All Insurance providers must be licensed by the Cayman Islands Monetary Authority ("CIMA") prior to effecting a contract of insurance in the Cayman Islands.
b. All Health Insurance providers effecting a contract of health insurance in the Cayman Islands must be approved by the HIC to do so.
c. All Approved Insurers have to offer the Standard Health Insurance Contract (SHIC)

d. All Approved Insurers must accept new applicants on cover under the SHIC with no limitations or exclusions, and only asking very specific questions of the applicant using the approved SHIC Health Insurance Application form.
e. An applicant must be enrolled on to, at minimum, a SHIC plan by the Approved Insurer within 10 working days of the date of submission of the application.
f. Even on a non-standard plan, an Approved Insurer cannot apply exclusions/limitations that take the applicant's level of coverage below what a SHIC plan would cover.
g. An applicant who has been covered for the previous 12 months with a break in cover of no more than 3 months must be covered with no additional limitations or exclusions than they had on their previous cover. This obligation is referred to as portability and applies to non-standard plans as well as the SHIC.
h. Approved Insurers are required to verify benefits when an individual goes for a healthcare service and their healthcare provider requests confirmation of coverage and benefits (as described in No. 5 above).
i. Approved Insurers are obligated to pay healthcare providers who have submitted a clean and complete claim for the amount that would have been covered by the insurance plan and to reimburse the client for anything that they have paid, which should have been covered by the plan within 30 working days of receipt of the complete claim form.
j. Approved Insurers are required to provide a report of the census of their portfolio and pay a tax into the segregated insurance fund for each individual and each family covered on their plans on a monthly basis.
k. Approved Insurers must submit an application for an Approved Insurers Certificate on an annual basis with a list of attachments. Attachments requested are not the same every year, but for the past year the information requested has included:
    i. A completed application form.
    ii. A filing fee of CI$1,500.00
    iii. A copy of a Letter of Good Standing from the Cayman Islands Monetary Authority
    iv. A copy of Audited Financial Statements for the prior year
    v. A copy of the year end filing that was submitted to CIMA for the prior year
    vi. A copy of any new or revised health insurance contracts with supplemental healthcare benefits &/or supplemental medical benefits
    vii. Information on In-Network Medical Providers
    viii. Agreements with Brokers and Agents
    ix. Local Personnel Information
    x. Overseas Key Personnel Information
    xi. A completed Operational Functions Questionnaires

l. Approved Insurers (as well as all other insurers registered in the Cayman Islands) are required to file annual returns with the Registrar of Companies and CIMA

m. Approved Insurers, like almost all financial services institutions licensed by CIMA, are required to file their financials annually with CIMA.

n. Approved Insurers are inspected annually by HIC and audited periodically by CIMA

o. Approved Insurers are required to provide information requested to CIMA. An example of a recent request for information received in 2019 in advance of an inspection is as follows:

    i. Current group structure of the Licensee;
    ii. Current organization chart including reporting lines;
    iii. Current Register of Shareholders;
    iv. Current Register of Directors and Officers as filed with the Registrar of Companies;
    v. Most recent management accounts of the Licensee;
    vi. A copy of the most current Business Plan;
    vii. Copies of 2019 reinsurance agreements (where applicable);
    viii. Copies of all Insurance Policy wordings;
    ix. Disputed claims log (In Excel Format);
    x. Claims listing for 2018. Details to include the insured, class of business, date of notification, causes of loss and date of claim settlement (In Excel Format);
    xi. A list of all underwriting policies for 2018. Details to include the insured, class of business, sum insured, premium paid and period of insurance (In Excel Format);
    xii. A list of all insurance agents and brokers used by the Company;
    xiii. Corporate Governance Framework including:
        A. Board structure, including committees and committee members
        B. Board and other Committee charters
        C. Board of Directors and Management committee minutes for all meetings held from inception to date along with any presentations to the board or its committees
        D. Conflicts of Interest policy
        E. Remuneration Policy
        F. Succession Plan for Directors, Officers, and Key Employees
    xiv. Internal Audit and Compliance Reports from inception to date;
    xv. Policies and procedures manual of the Licensee for the major risk areas including:
        A. AML/CFT/PF and Compliance manuals, including AML/CFT/PF Handbook
        B. Know-your-Client and Due Diligence manuals

C. New Business Acceptance policies and Procedures
D. Accounting and Financial Reporting policies and procedures
E. Information Technology policies and procedures
F. Record keeping and retention of documents policies and procedures
G. Product Development
H. Underwriting
I. Reserving
J. Claims Handling
K. Complaints handling
L. Asset/Investment Management
M. Process for handling Cancelled Policies
N. Any other relevant manuals, handbooks or guidelines in use

xvi. Details of outsourcing arrangements, including outsourcing arrangements with related parties:
A. A log of outsourcing arrangements
B. Copies of standard relevant outsourcing agreements including confidentiality agreements
C. Details on the process and criteria used to assess performance
D. Outsourcing policy, including supporting risk assessment and due diligence documentation, if any
E. A diagram depicting any material critical intercompany outsourcing arrangement

xvii. A listing of all bank accounts that the licensee holds, including account number, name and location of bank, type of account, and purpose of account;

xviii. Most current list of authorized signatories by bank;

xix. Details of any litigation against the Licensee; or confirmation there is none;

xx. Disaster Recovery/Business Continuity Plan along with the Business Continuity Training Program/policy and results of the most recent testing conducted;

xxi. Copy of the Risk Management Framework, including
A. Any capital assessment documentation
B. Any stress testing and scenario testing documentation
C. Any risk management-related procedures, policies, manuals and tools

xxii. Details of any reports produced by auditors, consultants, etc. at the request of the Licensee.

xxiii. Contact information of the Licensee's external auditor;

xxiv. Management letter issued by external auditor;

xxv. AML Training logs together with copies of training materials;

xxvi. Completed Information Systems Questionnaire;
xxvii. Completed Self-assessment Questionnaire;
xxviii. Sample of Authorized signatures for KYC approvals;
xxix. Complaints Log;
xxx. Suspicious Activity Reports log.

p. Approved Insurers are required to provide any info to the HIC upon request. An example of a recent request for information is one that was received in 2019, in advance of an annual inspection is as follows:
   i. Statistics of SHIC and Individual members as of Dec 2018 and May 2019
      A. Number of Enrollees per plan
      B. Number of Insured Lives per plan
   ii. Number of children insured 18 and under as of Dec 2018 and May 2019
   iii. Paid Claims for children 18 and under in one-year periods for 2017, 2018 and 2019
   iv. Top 5-10 frequently used CPT codes/diagnosis for children 18 and under
   v. Number of enrollees 65 and older
   vi. Paid Claim for enrollees 65 and older in one-year periods for 2017, 2018 and 2019
   vii. Top 5-10 frequently used CPT codes/diagnosis for enrollees 65 and older
   viii. Number of premature delivery claims in 2018 and 2019
   ix. Paid Claim Amounts for premature deliveries in 2018
   x. Any adjustments to policy documents or schedules of benefits? If yes, provide revised copies.
   xi. Report on turnaround time for claims
   xii. Number of claims submitted and processed for 2018
   xiii. Provide a report regarding the outstanding claims filed in excess of 30 days.
   xiv. Listing of all policies in a spreadsheet with policy number and renewal date.
   xv. Any changes to the organizational chart? If yes, provide an updated version.
   xvi. Copies of all SHIC application received for 2018
   xvii. Number of SHIC applications received for 2018 and 2019

The structures and obligations outlined above form the system of healthcare funding in the Cayman Islands. This system has evolved and been reformed periodically to accommodate a growing population and changes in the delivery of healthcare and financial services. No nation facing the dilemma of healthcare funding can claim to have found the perfect answer, but we take pride in the success that the Cayman Islands has enjoyed in being able to provide healthcare to its residents. The system does have its flaws. These are flaws which we do not believe to be fatal but simply gaps that need

to be closed for the needs of all to be met. In the subsequent Parts of this document, these gaps will be examined and proposals made to address them.