THE SOCIETY OF ACTUARIES IN IRELAND

Submission on the Health Insurance Authority's Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market

August 2010

Contents

1 Introduction

The Society of Actuaries in Ireland is the professional body representing the actuarial profession in Ireland.

We welcome the opportunity to provide input to the Health Insurance Authority's deliberations on risk equalisation in the Irish private health insurance market. We published a Working Group Report on risk equalisation in 2002 (http://bit.ly/SAI02RE). We have also expressed views through several press releases since then (https://web.actuaries.ie/press/press-release). In this submission, we now address specific questions raised by the Authority on the implementation of a risk equalisation scheme.

2 Executive Summary

The comments in this executive summary should be read in the context of the detailed responses contained in subsequent sections of this document.

Consideration of Different Risk Factors

Objectives of risk equalisation

Decisions on the risk factors to be taken into account in a risk equalisation scheme should have regard to, and be consistent with, the objectives of the scheme.

Our formal position on this matter, which was first stated in 2002 and re-stated in 2005 and 2009, is that it would be reasonable for the form of a risk equalisation scheme to encourage competition and new competing insurers. In this regard, we are in favour of a risk equalisation scheme based on age and gender, preferably on a prospective basis. Such a scheme goes some distance towards sharing of risk profiles between insurers but also favours new entrants to the market and would avoid the ambiguities and complexities of incorporating a utilisation parameter in the scheme.

If the risk equalisation system is to be designed such that it takes account of the viability of competition and new market entrants, our view is that there is no requirement for the scheme to go further than the partial equalisation of risk differences related to age and gender. In this situation, it is not necessary to allow for health status in the scheme due to the limitations on the ability of insurers to practice preferred risk selection with respect to health status (for example, insurers cannot readily identify the health status of prospective customers).

There is a suggestion in the consultation paper that unhealthy people may be less likely to switch insurer than healthy people. Thus, relatively new entrants to the market may be less exposed to the higher claims costs of unhealthy people than incumbent insurers. If this is the case, and the Government decides that one of the objectives of the risk equalisation scheme is to address differences in claims costs between insurers arising from the structure of the market (beyond those differences purely related to age and gender), and not to temper (or only partly temper) this objective with the goal of encouraging competition, then taking health status into account would make sense in that context. However, the rationale for doing so should be explicit and transparent, and targeted through clearly defined objectives.

In this response to the consultation paper, we focus primarily on the technical issues highlighted by the Authority's questions (- our views on policy issues may be read in the Working Group Report and press releases mentioned above). For many of the questions, the answer could be prefaced by "*it depends on the policy objectives decided by the Government relating to the strength and aims of the risk equalisation scheme, including the extent to which those objectives seek to promote competition in the market*". Thus, we suggest that the process of establishing a robust risk equalisation scheme must start with a clear statement of the objectives of the scheme, and subsequent decisions on risk factors to be taken into account should be demonstrably linked to those objectives.

Risk factors

Age and gender are core "underlying risk factors" (as defined in the Authority's consultation paper) that should be taken into account in a risk equalisation scheme.

If, having regard to the objectives of the scheme, other factors (such as health status) are to be taken into account in the scheme, our view is that using "underlying risk factors", if practicable, would be preferable to using "diagnosis related risk factors" or "resource usage factors". Indeed, we do not think that using diagnosis related risk factors is practicable, for reasons explained in Section 3 of this document.

We also believe that other factors should be taken into account only if they satisfy the following criteria:

- A rigorous data analysis exercise identifies that the risk factor has a substantive impact on claims experience within age and gender;
- Credible and reliable data on the risk factor is currently readily available to health insurers; and
- The risk factors used should be capable of categorisation into a small number of discrete categories that have distinctive levels of health service usage, so that they can be incorporated into a simple formula-driven risk equalisation system;

Diagnosis related risk factors

There are significant practical limitations that would prevent a diagnosis-based approach to risk equalisation being implemented in a credible manner in the near future.

Resource usage factors

If resource usage factors are used, care would need to be taken to avoid the inadvertent creation of incentives for materially inefficient economic behaviour by insurers and other parties within the wider health system. We offer some suggestions for reducing the risk of creating these incentives in Section 3 of this document, including:

- The use of a proxy measure for resource usage, for example a binary indicator based on whether or not a customer has made a claim in the past five years; or
- An approach based on a small number of resource-usage bands, rather than a direct 1-for-1 link to resource usage;

Regardless of the method ultimately adopted for the specification of a future risk equalisation scheme, we are strongly in favour of a robust design process that includes appropriate regulatory impact analyses.

Further discussion on the above topics is contained in Section 3 of this document.

Benefits to be included

We propose that the median level of benefits purchased by insured customers is a suitable point for "capping" the benefits to be included in the risk equalisation calculations. We are in favour of including costs relating to a customer's use of primary care, preventative treatment or care in the community in the risk equalisation system only to the extent that those costs are incurred as substitutes for hospital-based expenditure. This will clearly require careful management to avoid the creation of undesired behavioural incentives by insurers or other parties in the wider health system.

It is important that the specification of the risk equalisation scheme is consistent with the design of the minimum benefit regulations, in order to both reflect the features of current health insurance products and medical treatments and permit future developments in those areas to be absorbed into the specifications in future.

Further discussion on this topic is contained in Section 4 of this document.

Transition arrangements

We are in favour of basing the mechanics of the new permanent risk equalisation scheme on the method of operation of the current interim scheme (the tax-based loss-compensation system).

Without commenting on the current parameters of the interim scheme, we believe that the mechanics of the current system have functioned well as a method of implementing an interim quasi-risk equalisation solution. We note, however, that the transparency of the current system may create a disincentive for younger customers to purchase health insurance.

Further discussion on this topic is contained in Section 5 of this document.

3 Consideration of Different Risk Factors

Questions are numbered as in the Authority's consultation paper.

Underlying risk factors

4.1 What are your views on using underlying risk factors in a risk equalisation scheme?

The consultation paper defines "underlying risk factors" as "factors for which there is an objective classification method which the insurer has no or limited effective means of controlling or interpreting but which may be expected to be correlated to the claims cost of an individual".

Our view is that the use of "underlying risk factors", if practicable, would be preferable to the use of "diagnosis related factors" or "resource usage factors". We do not, however, believe that this is likely to be the case.

Decisions on the risk factors to be taken into account in a risk equalisation scheme should have regard to, and be consistent with, the objectives of the scheme.

If the risk equalisation system is to be designed such that it takes account of the viability of competition and new market entrants, our view is that there is no requirement for the scheme to go further than the partial equalisation of risk differences related to age and gender. In this situation, it is not necessary to allow for health status in the scheme due to the limitations on the ability of insurers to practice preferred risk selection with respect to health status (for example, insurers cannot readily identify the health status of prospective customers).

There is a suggestion in the consultation paper that unhealthy people may be less likely to switch insurer than healthy people. Thus, relatively new entrants to the market may be less exposed to the higher claims costs of unhealthy people than incumbent insurers. If this is the case, and the Government decides that one of the objectives of the risk equalisation scheme is to address differences in claims costs between insurers arising from the structure of the market (beyond those differences purely related to age and gender), and not to temper (or only partly temper) this objective with the goal of encouraging competition, then taking health status into account would make sense in that context. However, the rationale for doing so should be explicit and transparent, and targeted through clearly defined objectives.

We consider that age and gender are core "underlying risk factors" and should be taken into account in a risk equalisation scheme.

There are many potential "underlying risk factors" which may help to predict the extent to which an individual will need to use health services. The consultation paper identifies a number of these, including disability status, address, occupation status, occupation, welfare support, mortality, living alone or maternity. There are many more, e.g. smoker status, weight/height ratio, exercise habits, alcohol consumption. We believe that any underlying risk factors (beyond age and gender) should be used only if the potential exists for insurers, whether explicitly or implicitly, to practice "preferred risk selection" by reference to those factors. Many underlying risk factors overlap in their effects and the use of multiple factors would require generalised linear modelling, which is unlikely to be practicable for a risk equalisation scheme and may pose logistical and policy-related issues.

For many of the questions posed in the consultation paper, the answer could be prefaced by "*it depends on the policy objectives decided by the Government relating to the strength and aims of the risk equalisation scheme, including the extent to which those objectives seek to promote competition in the market*". Thus, we suggest that the process of establishing a robust risk equalisation scheme must start with a clear statement of the objectives of the scheme, and subsequent decisions on risk factors to be taken into account should be demonstrably linked to those objectives.

Risk factors

Our view is that underlying risk factors other than age and sex should only be used if they satisfy the following criteria:

- The relevant data should already be available to health insurers on a reliable basis. Data obtained by health insurers from insured persons for the sole purpose of risk equalisation is unlikely to be sufficiently reliable. Moreover, the collection of such data by health insurers could provide an opportunity, perhaps even an incentive, to practice preferred risk selection. None of the potential risk factors listed in the consultation paper, other than address, meet this criterion. Insurers will generally have data relating to the occupation status of the policyholder, but not necessarily for other persons insured on the policy.
- The inclusion of underlying risk factors needs to be justified by rigorous data analysis identifying a substantive impact on claims experience within age and gender categories in the context of Irish private health insurance. Factors that are predictive of health resource usage in other contexts, for example in a primary care setting, or in other countries, may not necessarily meet this criterion. Therefore, a two-step process should be followed: data in respect of proposed underlying risk factors should first be collected for a period to facilitate the analysis described above, and only if this criterion is met should the relevant risk factors be used for the purpose of calculating risk equalisation payments.
- The factors used should be capable of categorisation into a sufficiently small number of discrete categories that have distinctive levels of health service usage, so that they can be incorporated into a simple formula-driven risk equalisation system. For example, in an Irish context, the data is not available to assess whether address is predictive of health service usage, but even if it were, it is unlikely to be amenable to categorisation for the purposes of risk equalisation.

4.2 What underlying risk factors should be used?

As noted above, age and gender are core underlying risk factors and should be used. We cannot identify any additional underlying risk factors that satisfy the criteria outlined in response to question 4.1. However, any such criteria that can be identified by the Authority having regard to the data available to health insurers could potentially be considered for inclusion.

4.3 What data should be collected from undertakings in respect of underlying risk factors?

Any data sought by the Authority should already be available to health insurers on a reliable basis.

The Authority should examine the data available to insurers to determine which, if any, merit testing for potential inclusion as underlying risk factors. Data could then be collected for any risk factor that satisfies any such initial analysis in order to determine whether its inclusion in a risk equalisation system can be justified. Alternatively, the Authority could undertake or commission analysis based on other datasets which include factors that have been identified as available to Irish health insurers.

If, however, diagnosis related or resource usage factors are included in a risk equalisation system, the collection of data in relation to underlying risk factors other than age and gender may not be warranted.

4.4 Should underlying risk factors be fully or partially equalised?

As discussed in our response to question 4.1, this issue depends on the regulatory criteria for a risk equalisation system and decisions on the risk factors to be taken into account (and the extent to which they are taken into account) in a risk equalisation scheme should have regard to, and be consistent with, the objectives of the scheme.

If the risk equalisation system is to be designed such that it takes account of the viability of competition and new market entrants, our view is that there is no requirement for the scheme to go further than the partial equalisation of risk differences related to age and gender.

If, however, the Government decides that one of the objectives of the risk equalisation scheme is to address differences in claims costs between insurers arising from the structure of the market (beyond those differences purely related to age and gender), and not to temper (or only partly temper) this objective with the goal of encouraging competition, then taking health status into account would make sense in that context. However, the rationale for doing so should be explicit and transparent, and targeted through clearly defined objectives.

Finally, it may be appropriate to fully equalise on the basis of some risk factors, such as age and gender, but to partially equalise other risk factors that are included in the risk equalisation system.

The critical point is that the relevant regulatory objectives should be identified and the inclusion of risk factors and the extent to which they are equalised should then be tested relative to those objectives and to appropriate regulatory impact analysis.

4.5 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?

4.6 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?

In order to establish confidence that the data returned is provided on a consistent basis, the data requirements need to be specified in sufficient detail and sufficient clarity that the scope for alternative interpretations is minimised. This may require that the statutory requirements are elucidated by means of guidance issued by the regulator; precedents for this exist in financial services and pensions regulation.

The regulator may also need to proactively investigate the basis on which the requirements have been interpreted by insurers by various means, which may include on-site visits to insurers.

We recommend that the Authority consults with the Irish Accounting and Auditing Supervisory Body in relation to specifying the audit requirements for data returns and with other regulatory bodies, including the Financial Regulator and Pensions Board, in relation to learning from their experiences in ensuring the consistency of data returned by regulated entities.

4.7 Would a risk equalisation system based on underlying risk factors (in addition to age and gender) be sufficiently effective in supporting community rating?

We understand that the data available to insurers in respect of underlying risk factors is very limited and, as outlined above, our view is that data should not be collected by insurers solely for the purposes of risk equalisation. If, therefore, risk equalisation based on age and gender is not considered sufficient, we consider it unlikely that the addition of underlying risk factors would be effective.

As noted previously, however, a successful community rated system requires that insurers continue to attract young healthy lives into the insured pool; full equalisation may reduce the incentive for insurers to target new entrants to the insured pool.

We also refer here to our answer to question 4.4.

Diagnosis related factors

4.8 What are your views on using diagnosis related risk factors in a risk equalisation scheme?

We do not think diagnosis-related factors represent a feasible basis for designing a risk equalisation scheme and therefore we believe that data should not be collected in respect of diagnosis-related factors.

If a health status measure is to be used in the formula the use of a diagnosis related approach could be considered the best way to do this. Nonetheless, it is extremely complex to introduce such a system and would require a considerable amount of credible data to be collected from insurers at the individual diagnosis level. We do not know if insurers collect this information at present, and even if they do, the data is unlikely to be credible given their relative size. Furthermore, the delay in introducing risk equalisation using this approach would be considerable as these issues are addressed.

Our opinion is that there are several significant difficulties that would preclude the implementation in the near future of a functional risk equalisation scheme based on the use of diagnosis-related risk factors (some of which have been identified by the Authority in the consultation paper), including the following:

- There are too many diagnosis-related risk factors in use to to permit practical segmentation;
- This large number of data groups leads to low credibility of experience within each group;
- Combining diagnosis-related factors into diagnosis-related groups leads to data heterogeneity;
- The potential exists for companies to adopt varying stances with regard to the recording of data;
- Insufficient data exists at present to allow for a prompt introduction of a risk equalisation scheme based on diagnosis-related risk factors, and there could be a substantial delay while such data is collected.

These represent significant practical limitations that would prevent a diagnosis-based approach to risk equalisation being implemented in a credible manner in the near future.

4.9 What diagnosis related factors should be used?

We refer to our comments in response to question 4.8.

4.10 What data should be collected from undertakings in respect of diagnosis related factors?

Notwithstanding our comments above, data should be collected in aggregate terms by age and gender cell at principal diagnosis level if it were to be used. Thus, each insurer would report its returns for each individual diagnosis related group (DRG). Of course, as part of this, all insurers must use the same International Classification of Diseases (ICD) version and the same diagnosis related grouping software.

4.11 What are your views on the difficulties in collecting and auditing data and how can these issues be best tackled?

Collecting and auditing data is particularly problematic when insurers are reporting inconsistent data, which is a greater risk when considering DRGs due to their complexity and the element of subjectivity that may exist. Furthermore, there needs to be a consistent approach to the auditing of returns.

In order to establish confidence that the data returned is provided on a consistent basis, the data requirements need to be specified in sufficient detail and sufficient clarity that the scope for alternative interpretations is minimised. This may require that the statutory requirements are elucidated by means of guidance issued by the regulator; precedents for this exist in financial services and pensions regulation. The regulator may also need to proactively investigate the basis on which the requirements have been interpreted by insurers by various means, which may include on-site visits to insurers. We recommend that the Authority consults with the Irish Accounting and Auditing Supervisory Body in relation to specifying the audit requirements for data returns and with other regulatory bodies, including the Financial Regulator and Pensions Board, in relation to learning from their experiences in ensuring the consistency of data returned by regulated entities.

4.12 Do issues arise for private and public hospitals?

The key issue is that treatments should be allowed in a consistent manner regardless of the setting of the patient.

4.13 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?

As identified above, the Authority has an important role in ensuring that all returns are validated and are consistent. To do this, they need to understand, amongst other things, how the returns are generated by each insurer and how different classes of claim event are allowed for within the returns of each insurer, which may be particularly difficult to achieve for DRGs. This may mean carrying out on-site visits to insurers.

We cannot provide a precise cost for the nature of activities. However, the cost is likely to be small in comparison to the amount of money that will be transferred between insurers.

4.14 Should the differences in costs between different diagnosis risk factors be fully or partially equalised?

We refer again to our comments in section 2 of this response, and our reply to question 4.1 about the need for consistency between the design of the risk equalisation scheme and the objectives of the scheme. Notwithstanding those comments, and our views contained in the response to question 4.8 about the feasibility of introducing such a system, a diagnosis based approach is likely to be a good measure of the differences in health status.

4.15 Would a risk equalisation system based on diagnosis related factors be sufficiently effective in supporting community rating in the best interests of consumers?

We refer again to section 2 of this document (and the reply to question 4.8), and the need for consistency between the design of the risk equalisation scheme and its objectives.

4.16 Should insurers provide the data at a DRG level or at DRG category level?

We believe that neither option is suitable, as data collected at a DRG category level is likely to contain insufficient detail to be useful, while data collected at a DRG level would be expected to suffer from a lack of statistical credibility.

4.17 How would you adjust the DRG approach in order to avoid a bias towards hospitalisation where effective treatments outside of hospital are available and to allow for the rewarding of appropriate use of preventative medicine / treatments?

We note that the purpose of DRG is to classify hospital episodes, rather than to take account of medical treatment outside of hospital-based settings. This complication illustrates a further reason why we are against the use of a DRG approach.

Resource usage

4.18 What are your views on using resource usage related risk factors in a risk equalisation scheme?

We refer again to the comments contained in section 2 of this document regarding the need for the design of a risk equalisation scheme to be consistent with the objectives of the scheme.

There are several specific difficulties with using resource usage related risk factors in a risk equalisation scheme:

- There are considerable dangers that using resource usage as a rating factor will lead to unintended negative consequences for the market as a whole in terms of product structuring, deals with hospitals that adjust the resource usage reported at individual level, etc. These dangers are alluded to in the consultation document
- The consultation paper also refers to the dangers of such a system related to equalisation of higher end benefits. This would be particularly unfair to competitors with relatively more members on lower level plans. These competitors do not benefit from the higher premiums associated with higher level plans but would suffer from risk transfers to competitors that do have such plans.

4.19 What resource usage factors should be used?

If resource usage factors are used, care would need to be taken to avoid the inadvertent creation of incentives for materially inefficient economic behaviour by insurers and other parties within the wider health system:

- Using cost would reward competitors who have agreed relatively unfavourable terms with providers, i.e. it would share efficiencies and inefficiencies between competitors;

- Using hospital days reduces the incentive to negotiate lower hospital days and reduces the benefit of doing so hence increasing the cost of health insurance for all;

Even if the difficulties envisaged in relation to question 4.18 could be overcome, it is difficult to see how a resource usage factor could be found that does not create problems of measurement and perverse incentives to competitors, although we suggest that this could potentially be at least partly achieved through the use of:

- The use of a proxy measure for resource usage, for example a binary indicator based on whether or not a customer has made a claim in the past five years; or
- An approach based on a small number of resource-usage bands, rather than a direct 1-for-1 link to resource usage;

The use of pharmaceutical cost groups is mooted in the consultation paper. The use of this factor has not been shown to be effective in a system geared towards hospital (as opposed to total medical) reimbursement. Also if such a system were to be used it would be necessary to track which pharmaceuticals were used and standardise such costs rather than using actual cost of such drugs.

4.20 What data should be collected from undertakings in respect of resource usage factors?

The Authority may consider gathering data over several years to continue to monitor the relationship between resource usage and health status. However, it is difficult to see how information beyond hospital days and total cost can be standardised.

4.21 Should the differences in costs between different resource usage risk factors be fully or partially equalised?

We refer to our comments made in response to question 4.4.

4.22 Would a risk equalisation system based on resource usage related risk factors be sufficiently effective in supporting community rating?

We refer again to the opinions expressed in section 2 of this document (and the reply to question 4.8), regarding the need for consistency between the design of the risk equalisation scheme and its purpose.

Proxies for health status

4.23 This consultation paper has suggested some possible measures of health status (underlying risk factors DRGs, hospital utilisation etc) that could be used in addition to age and gender. Are there other measures that might be adopted?

If the Government decides that one of the objectives of the risk equalisation scheme is to address differences in claims costs between insurers arising from the structure of the market (beyond those differences purely related to age and gender), and not to temper (or only partly temper) this objective with the goal of encouraging competition, then taking health status into account would make sense in that context.

In our response to question 4.1, we set out the criteria that we believe should be met for any underlying risk factors to be used as proxies for health status measurements.

If additional factors are to be used as possible measures of health status, it is important that they are simple and objectively measurable and we do not believe that such other factors exist for this purpose.

4.24 Is it necessary to use more than one health status measure in a risk equalisation system, in order to ensure that it is effective in supporting community rating?

On a technical matter, it is not possible to answer the question as to whether more than one health status measure would be needed to equalise health status differences as it would depend on the measure or measures to be used and the extent to which they correlate with residual risk differences.

4 Benefits to be included

Questions are numbered as in the Authority’s consultation paper.

5.1 To what extent should costs incurred in providing primary care, preventative treatment / care and care in the community be included in the system?

Our opinion is that costs relating to a customer’s use of primary care treatments should be included within the risk equalisation system only to the extent that those costs are incurred through the use of primary care treatment as a substitute for treatment in a hospital setting. We believe that this will promote equitable treatment within the risk equalisation system of comparable medical costs regardless of the setting in which they are administered, and will also reduce the risk of the risk equalisation results being distorted by patterns of primary care costs. We recognise that there would be significant practical issues in classifying primary care costs in this manner, but we believe that a focus on assessing costs using a substitutive criterion would be beneficial.

While preventative care is to be encouraged as a means for reducing overall medical costs, and ultimately acting as a substitute for hospital-based costs, we believe that the inclusion of preventative care in the risk equalisation specifications would require careful definition in order to avoid creating any incentives for perverse behaviour by insurers, hospitals or other medical treatment providers. A balance needs to be found between not discouraging preventative care with specific targeted purposes, and not inadvertently encouraging unnecessary excess expenditure.

With regard to care in the community, our opinion remains consistent with the broad aim of recognising expenditure where it is incurred as a substitute for hospital-based care. Care in the community should be included within the risk equalisation specifications provided it is a substitute for hospital-based care, but we believe that costs related to long-term care (whether in a nursing home or a patient’s private residence) should not be included.

It is also important that the inclusion (or exclusion) of these various types of care within the risk equalisation system should be consistent with their treatment under any revision to the minimum benefits regulations. If a particular type of treatment (for example, some primary care treatments) is included in the minimum benefits regulations, then it would be appropriate also to include it in the risk equalisation specifications.

The risk equalisation system specifications should contain sufficient flexibility to allow in due course for the inclusion of new medical treatments, and to reflect future changes in the methods of delivery of medical treatment in Ireland.

5.2 How should the limits be set so as to exclude what may be regarded as luxury benefits? How should these limits be updated / kept under review?

Our view is that the median level of benefits purchased by the insured customers is a suitable point for “capping” the benefits to be included in the risk equalisation calculations.

This should be achieved by way of a broad approach to the design of the risk equalisation system, rather than by specifying individual benefits for inclusion or exclusion. It will also be important for this purpose that the structure and operation of this aspect of the risk equalisation system should be consistent with the new minimum benefits regulations.

We recognise that there needs to be a balance between customers on lower-level plans not bearing an undue burden of increased premiums due to risk equalisation, and achieving a risk equalisation system that takes account of the health insurance benefits purchased by the majority of the population. We believe that the use of the median level of benefits as the ceiling for the risk equalisation system would represent a reasonable compromise between these two aims.

We also suggest that it may be worth investigating whether or not customers aged less than 18 account for a significant proportion of those customers who have only purchased cover in public hospitals (as shown in the table on page 36 of the consultation paper), as otherwise this statistic may not fully represent patterns of benefit coverage among Irish adults.

5.3 Should fixed price procedures be subject to different limits than other forms of treatment? How should fixed price procedures be defined?

It is important, as a fundamental principle, that the risk equalisation specifications should be defined in a consistent manner according to the medical procedure or treatment, instead of by reference to the reimbursement arrangements between a hospital and an insurer.

This approach will allow for consistency with the minimum benefits legislation, and also with the boundaries of the range of benefits to be included within the scope of risk equalisation (see our response to question 5.2).

It would also reduce the potential for imbalances between similar medical procedures or identical medical procedures being performed in different hospitals (for example, the variation in costs between public and private hospitals, which can be positive or negative, depending on the hospitals and procedures involved).

5 Transition Arrangements

Questions are numbered as in the Authority's consultation paper.

6.1 What are the views of stakeholders in relation to this approach?

We are strongly in favour of basing the mechanics of the new permanent risk equalisation scheme on the method of operation of the current interim scheme (the tax-based loss-compensation system).

Without commenting on the current parameters of the interim scheme, we believe that the mechanics of the current system have functioned well as a method of implementing an interim quasi-risk equalisation solution.

A tax-based loss-compensation system is capable of being extended to give a result that will be broadly consistent with the intended outcome of the proposed long-term risk equalisation scheme. This could be done relatively simply through alterations to the parameters of the current scheme to reflect the outcome ultimately sought by the Department of Health & Children.

6.2 What type of data would be necessary under this approach in order to assess the extent to which differences in claim costs for each age group between insurers arise from health status differences or from other causes?

In terms of the examination of differences in claim costs, the same data considerations would arise under any transitional scheme as for the long-term risk equalisation scheme. We re-iterate the comments contained in our responses to similar questions contained in section 4 of the consultation paper.

6.3 Would it be possible to adapt this kind of approach when designing a robust system? How would this be done?

We also believe that a tax-based loss-compensation system merits significant consideration as the method of delivering the longer-term risk equalisation scheme, on the grounds that the current interim system appears to be legally robust and has already facilitated transfers between insurers. Being able to alter the current system to achieve transfers that are broadly equivalent to those under a "robust" scheme simply by changing the parameters of the premium levy and tax credits is an attractive way of promptly and simply implementing the long-term solution without the risk of lengthy delays from legal challenges (because the transfers are effected through the tax system rather than a separate legislative framework).

It also contains the advantages of other prospective risk equalisation schemes by providing clear and simple communication to insurers of the parameters under which they will be operating, as well as easily allowing for any subsequent changes deemed necessary (for example because of changes in risk factors, claims experience, benefit levels) by way of further amendments to the premium levy or tax credits.

We are in favour of this system being used along with sufficient advance notice periods of the level of the premium levies and tax credits for each year. We also call for a high degree of transparency with regard to the calculations used for setting the premium levies and tax credits each year, so that consumers and industry can have confidence in the process.

We note that the use of a tax-based system increases the visibility of the cost of risk equalisation to younger customers.

While our comments on this mechanism are made in the belief that it will not be used as another form of revenue-raising taxation by the government, we do note the potential threat to government revenue from the risk that the tax-based scheme may not be in balance every year. We believe this could be accommodated by including a prior-year adjustment within the annual process of setting the levels of the premium levy and tax credits, which would allow for any deficits or surpluses brought forward from previous years to be eliminated.

With regard to the operation of the current system, we are aware that it leads to some accounting imbalances due to a mismatch between the timing of the accrual of the tax credits and premium levies. We recommend that this feature be remedied in any long-term system.

6 Other Issues

Questions are numbered as in the Authority's consultation paper.

7.1 Should the system include special provisions for new entrants? How should these positions be framed?

Our view is that, while it is desirable for the *market as a whole* to attract and retain new and healthy members, it is not desirable to include a special provision that would disproportionately incentivise the new entrant segment of the market to practice preferred risk selection.

If there is a political decision to encourage new entrants to stimulate competition in the market this could be achieved in other ways, such as a specifically targeted subsidy.

7.2 Should the risk equalisation transfers take into account the amount of lifetime community rating loadings that an insurer receives and if so, how should the transfers incorporate these loadings?

Theoretically, loadings that an insurer receives under lifetime community rating should be taken into consideration as these will contribute to the cost of insuring older people. However, as these loadings will apply only to older customers who are new to the market, they are likely to be immaterial in the immediate future. We suggest that these are only included once a materiality threshold has been breached.

7.3 How should the new risk equalisation scheme take account of changes in minimum benefit regulations?

We refer to the comments expressed in response to questions to 5.1 to 5.3

7.4 Should the risk equalisation calculations of the Health Insurance Authority be published?

The decision on what data to publish should balance the need for commercial confidentiality against the level of transparency that is required to allow all insurers in the market have confidence that the system is being implemented objectively. Our view is that market data should be published but not the data of individual insurers.

If the current tax-based loss compensation system is extended (or other prospective system introduced), then the net cashflow across the market (i.e. the total of all positive and negative transfers between insurers) should be published, together with the resulting adjustment to parameters for the following year. We also call for a high degree of transparency with regard to the calculations used for setting the premium levies and tax credits each year, so that consumers and industry can have increased confidence in the process being followed. In addition, it is important that the parameters for the next financial year are published early enough to allow insurers to adjust the prices of their policies accordingly.

THE SOCIETY OF ACTUARIES IN IRELAND

102 Pembroke Road, Dublin 4, Ireland

Tel: +353 1 660-3064 Fax: +353 1 660-3074

e-mail:info@actuaries.ie website: www.actuaries.ie