THE SOCIETY OF ACTUARIES IN IRELAND

Submission on the Health Insurance Authority's Consultation Paper on Minimum Benefit Regulations in the Irish Private Health Insurance Market

September 2010

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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 Minimum Benefit Regulations in the Irish private health insurance market. We would be happy to elaborate further on any points made in this submission, if required.

2 Overall Comment

Basis for Minimum Benefits

The Society's view is that the basis for determining the Minimum Benefit should be determined on a "lowest market cost" approach.

We are not in favour of either the automatic production of prescriptive schedules or a system that is entirely based on the exercise of discretion by the Authority from time to time. We believe that a principles-based system should be implemented, whereby cover would be provided for all necessary medical treatments and the basis for determining the "lowest market cost" would be clearly defined. Insurers could then apply this basis, and the Authority could use it to adjudicate[1] on whether an insurer's payments met the requirements, as and when needed.

Scope

As per the consultation paper, the principal objective for the Minimum Benefit Regulations is the support of community rating.

It is also suggested in the paper that Minimum Benefits should emphasise the trend towards primary care, care in the community and chronic disease management.

We acknowledge and respect the desired outcomes of the government's current healthcare policy and the primary care strategy. However, given the primary objective of the Minimum Benefit Regulations, we question the appropriateness of using the Regulations to help bring about these outcomes. Doing so could conflict with and undermine the primary objective of the Regulations:

- The extension of Minimum Benefits is likely to have an inflationary impact on insurance costs - for example, if primary care is added other than on the basis that an insurer may choose to pay for primary care as an alternative to paying for cover provided in a more expensive setting;

[1] Subject to being given power to do so.

- Where this leads to cancellation of insurance, it will be those less likely to claim who are more likely to opt out, causing further inflation pressures;

- The extension of Minimum Benefits may be counterproductive to the principal aim of the Regulations in that the increased cost may mean that younger people do not take out insurance. One of the government aims is to encourage this sector to buy insurance since they subsidise those at older ages. The stability of this cross-subsidisation underpins community rating.

Network

One of the areas not discussed in the consultation paper is the sophistication of the provider network (i.e. number and geographic spread of hospitals or other treatment centres covered by an insurer). While currently network is not used as a selection tool, it is possible for insurers to restrict cover for certain services to certain service providers. This could have the same effect as not providing the benefit. We recommend that this be considered in the Minimum Benefit Regulations.

3 Consultation Questions

Q1 Which services should be included in Minimum Benefit Regulations, or alternatively, how should the benefits to be included in Minimum Benefit Regulations be determined?

Our opinion is that the services covered by the Minimum Benefit Regulations should be all services arising from medically necessary treatment carried out in a hospital setting (including associated drug costs, whether administered in hospital or in a primary care setting[2]).

Insurers should be allowed to encourage primary care treatment where this substitutes for treatment in a hospital setting, and will be incentivised to do so if primary care treatment comes at a lower cost. However, the Regulations should not require them to do so (except in respect of associated drug costs, as indicated above), because this would bring benefits currently not covered by most health insurance policies into all policies. This would have inflationary consequences for insurance premiums, potentially leading to affordability issues, cancellation of policies (particularly by healthy people, creating further inflationary pressure) and difficulty in attracting young people into the insurance pool.

The Regulations should be reviewed again at a later date, when the primary care infrastructure is better established, to determine whether it would be appropriate, on the basis of the health care systems then in place, to include primary care under the Minimum Benefit Regulations.

[2] An example of such a drug therapy would be in relation to chemotherapy provided to a patient at home rather than in a hospital setting.

Q2 At what levels should minimum payment levels be set, or alternatively, how should minimum payment levels be determined?

We propose that minimum payment levels should be set equal to the "lowest market cost" for the relevant treatments. Insurers would determine "lowest market cost" for a hospital treatment based on the participating hospitals and consultants relevant to the insurer. Provision should be made for the Authority, or another appropriate body, to adjudicate in the event of dispute as to whether an insurer's provider network facilitates access to the full spectrum of treatments within reasonable geographic reach of insured persons.

Q3 What measures are necessary to ensure that the list of services remains up to date with medical developments?

As indicated above, we believe that it is not necessary to set out a list of services. Rather, a principles-based approach should be adopted, whereby all services provided as part of hospital care are covered by the Minimum Benefit Regulations. Treatments emerging from new medical developments would then be included automatically.

Q4 How should provision be made for future changes in the cost of medical services?

Since the above suggestion is principles-based, there is automatic provision for future changes in the cost of medical services.

Q5 Should excesses on claim benefits be provided for explicitly in the Regulations? In particular, should there be limits on excesses?

In our opinion, excesses on claim benefits should be provided for explicitly in the Regulations. There should be limits on excesses, as not having such limits would subvert the intergenerational solidarity principle of community rating. Ideally, no explicit amounts would be set as these would go out of date and require review. However, a rule based on premium and Minimum Benefit payment may be practicable. For example, the Regulations could prescribe that the maximum excess per annum shall be the higher of the relevant adult premium and a specified proportion of the benefit payment.

Q6 Should the manner in which minimum payment levels are specified be simplified, and if so, how?

Yes, as described above (Q2-4).

Q7 What are your views on the possible approaches for simplifying the specification of minimum payment levels referred to earlier?

We agree that it would be beneficial to simplify the requirements by avoiding a detailed list of procedures. Please see our comments above (Q1 and Q2) on what services should be included and how the payment levels in respect of those services should be determined.

In relation to the possible simplifications outlined on page 5 of the consultation paper:

- We believe that the first of the two possible approaches outlined would be inflationary as the cost of treatment in a public hospital setting may be greater than the cost in a private hospital. Therefore, the proposed approach to setting the required level of monetary cover may eliminate the insurer's ability to negotiate prices with private hospitals.
- The second of the two possible approaches is broadly similar to our proposed approach, which involves assigning a function to the Health Insurance Authority. However, our preferred version of this approach is that the Authority would be given the power to adjudicate in the event of dispute as to whether the benefits provided by an insurer satisfied the principles-based criteria included in the Regulations, rather than being required to determine/specify each and every service to be covered and the cost level to which they would have to be covered. Our proposed approach would not preclude the Authority from developing comprehensive schedules of services and minimum benefits in support of its adjudicatory role, but the facility for the Authority to operate an "exceptions"-based approach should be less resource intensive and should provide greater scope for the evolution of medical services and insurer/provider contracting.

Q8 How should recent developments in healthcare and healthcare policy (including with regard to primary care and chronic disease management) be reflected in Minimum Benefit Regulations?

Q9 Which primary care and chronic disease management services should be covered by Minimum Benefit Regulations and to what extent?

Q10 Do practical issues arise with respect to including primary care benefits in Minimum Benefit Regulations? How could such issues be addressed?

Q11 What are the other consequences of including primary care and chronic disease management in Minimum Benefit Regulations?

In relation to the above questions 8 – 11, please refer to our answer to question 1.

Extending Minimum Benefit payments to include primary care and chronic disease management could have an inflationary impact on insurance costs, as explained above. This would undermine the solidarity principle of community rating – the more that benefits are enriched, the more expensive insurance becomes, creating affordability issues and making it more difficult to persuade young people to buy insurance.

Q12 A significant requirement of the current Regulations relates to private care in public hospitals. Should the Regulations provide for a possible reduction in private services in public hospitals, if so how?

As set out above, we propose that Minimum Benefit payments be equal to "lowest market cost". This should remove the inequality of services between private and public. There should be no difference in whether the treatment takes place in a private or public setting.

Q13 How should the Minimum Benefit Regulations recognise the interaction of private healthcare provision in public hospitals with provision in private hospitals and other private provision?

If Minimum Benefit payments are structured as proposed above, no issue arises.

Q14 How do the current Minimum Benefit Regulations impact on the economic efficiency within the health insurance and private healthcare markets?

Minimum Benefits, and in particular changing Minimum Benefits, can have a tendency to be inflationary. If a provider is aware that certain services must be covered under private health insurance contracts, and in particular in circumstances where competition between providers is limited, the economic likelihood is that the price of such services will be higher than it would otherwise have been.

A particular example arises in relation to public hospitals. The rates charged are set by central government, essentially based on the budgetary needs of the public hospital sector. Insurance companies are required to provide coverage at the rates dictated but do not have any influence over those rates. This implies that there is no incentive for economic efficiency in public hospitals in relation to the private provision of health services.

Q15 What impact would you expect the amendments discussed in this paper to have on economic efficiency within the health insurance and private healthcare markets?

Extension of the scope of Minimum Benefits is likely to be inflationary in relation to the provision of the additional benefits.

Improving patient experience and healthcare outcomes is clearly a desirable objective but requiring coverage of primary care (for example) within Minimum Benefits is not likely to achieve this in an economically efficient manner without fundamental changes to the health system and to how care is delivered in aggregate. Mandating the coverage of new benefits cannot of itself bring about the intended changes.

Q16 Do you consider that some changes to the Minimum Benefit Regulations are warranted in order to achieve more economically efficient provision of private health insurance or private healthcare, while providing the best healthcare outcome? If you do, please describe the changes that you consider are warranted.

An important aspect of economic efficiency in healthcare is to ensure that there is scope to encourage more efficient use of resources. This can include providing health services in a lower cost environment. Changes to Minimum Benefits may be warranted in order to permit insurers to dictate that certain services may be provided in a non-hospital setting (while not obliging them to do so, for reasons outlined above at Q1).

Q17 Do you consider that amendments to the Minimum Benefit Regulations are required in respect of maternity, psychiatric, addiction related or step-down nursing home care?

Given that maternity services are services that are used for insurers to provide selective benefits to preferred risks and also the fact that such services are essentially non-insurance benefits provided on a 'grant-in-aid' basis, we do not believe they should be included within Minimum Benefits.

Psychiatric and addiction services should be provided on a similar basis to other services with the possibility, for insurers, of providing non-inpatient services as an alternative to in-patient services if clinically appropriate. We do not see any need to changing the current limits with respect to the number of days of in-patient treatment (e.g. 100 days or 91 days) but we recognise that the choice of the appropriate minimum number of days is somewhat arbitrary.

Step-down nursing services can constitute legitimate medical care for some patients. However, given that the benefit currently provided by the market is reasonably low for this service, providing it as a Minimum Benefit could tend to increase premiums.

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