Society of Actuaries in Ireland

Response to the Public Consultation on the

White Paper on Universal Health Insurance

28th May 2014

Contents

1 Introduction

1.1 The Society of Actuaries in Ireland is the professional body representing the actuarial profession in Ireland. Many of our members hold responsible roles within, or as advisers to, financial services firms, including health insurers. They act as board members, Signing Actuaries (with statutory responsibilities relating to reserving for insurance liabilities) and senior managers carrying a range of responsibilities. The Society seeks to make an impartial contribution to public debate on social policy and public interest matters where an actuarial perspective can add value.

1.2 Within the healthcare industry, actuaries' core competencies include estimating future morbidity rates and patterns and the corresponding costs of care. Actuaries advise on premium rates, benefits, reserving, capital needs, underwriting, administration and the management of insurance risk. Actuarial skills and experience can be applied to understand the financial challenges in the provision of healthcare and to identify opportunities for improved efficiency.

1.3 Actuarial models can project the financial implications of potential health service designs and funding structures under a variety of different economic and demographic scenarios. In particular, they can reflect the significant challenges our ageing population will present to the provision of healthcare. They can be used to illustrate the operational aspects of different programmes in order to compare efficiencies and estimate resource requirements. Such tools allow a thorough assessment of prospective approaches, giving the insight needed to create cost-effective and affordable solutions.

1.4 We welcome the opportunity to submit this response to the Department of Health's Public Consultation on the White Paper on Universal Health Insurance (UHI). We support many aspects of the White Paper, such as the continued commitment to developing an efficient healthcare system that will deliver quality services to patients.

1.5 We provide an overview of our key comments in Section 2, followed by more detailed comments in the remaining sections as follows:

Section 3: Capital

Section 4: Benefits

Section 5: Costing

Section 6: Regulation

In addition, in the Appendix, we provide cross-references to sections of this response that are relevant to specific questions raised in the Public Consultation.

1.6 We do not comment in this submission on pros and cons of Universal Health Care. Nor do we compare this model with other possible approaches or provide a view on the timescales set out in the White Paper. Rather, our responses are presented on the basis that Universal Health Care, based on universal insurance and competing insurers (as outlined in the White Paper), is government policy and will be introduced in the proposed timescale.

1.7 We would welcome the opportunity to engage further with the Department of Health on the topics raised in this response.

2 Summary of Key Comments

Capital (see section 3)

2.1 One of the major omissions from the White Paper is any consideration of the regulatory capital consequences for health insurers of moving to UHI.

2.2 The total level of regulatory capital required by insurers to operate a UHI system in Ireland will be very substantial. We estimate that the additional regulatory capital required could be between €1.6bn and €2.4bn.

2.3 Obtaining a significant increase in regulatory capital is not straightforward. It is important that the design and implementation of the UHI system is transparent to potential capital providers and that they have reasonable confidence in UHI's success and long-term stability and therefore that a commercial return on the invested regulatory capital is achievable.

2.4 Insurers will, in practice, pass the cost of obtaining this capital onto customers in the form of higher premiums. Collectively, this cost of capital will likely amount to several hundred million euros a year.

2.5 There is a regulatory mechanism for the UHI capital requirement to potentially be substantially reduced under the new regulatory capital framework to be introduced in 2016 by the European Insurance and Occupational Pensions Authority, called Solvency II. The Central Bank of Ireland (CBI) will, in practice, decide whether any such UHI capital reduction is warranted under this regime. In this context, the Society recommends that the Department of Health collaborates with the CBI in the design and implementation of UHI.

Benefits (see section 4)

2.6 We note that tensions will exist in ensuring comprehensive health services are included (in the basket of healthcare services and the insurance package of services) and in managing the cost constraints (both taxation and compulsory insurance premiums).

2.7 A full and open consultation will be required as part of the assessment of what is to be included in the basket of services. This consultation should involve all stakeholders, including the general public, the health insurance industry and indeed the actuarial profession, who have expertise in assessing the financial impact of providing the basket of services to an evolving demographic.

2.8 Once the basket and insurance package have been established, there should be transparency and oversight around the framework for making potential changes and the resulting consequences; for example, this would avoid the insurance package being used inappropriately as a mechanism to transfer costs from central health spending to the insurance sector.

2.9 Key factors in the successful implementation of UHI will be insurers' ability to operate efficiently and obtain competitive rates from providers – notably hospitals. As well as efficiency of operation, healthy competition will be required – and the market will require the participation of a number of insurance companies to be viable. Elements to support a viable insurance market that will need closer consideration include the following:

- The proposals on caps on insurer profits, expenses and claims. Such caps may be detrimental to the market as a whole. For example, the market may not remain attractive to a sufficient number of insurers and innovation may be stifled.
- It will be important that the Efficient Market Rate is set at a level that allows insurers to be profitable in accepting risks from the population paid for by the State.
- Allowing scope for insurers to offer supplementary insurance cover and how this segment would operate in practice.

Costing (see section 5)

2.10 The cost of delivery of both the basket and the insurance package will be a key issue under the UHI system. We believe the following principles for costing are important in order that managed competition can be effective in controlling cost:

- The UHI system should create incentives for competition between providers and insurers that will encourage the most efficient use of health care.
- The practicalities of pricing and consumer protection need to be taken into account. For example, given the nature of healthcare we believe that costing should be undertaken on a one-year funded basis and, thus, premiums should be set annually.
- The system should be self-funded insofar as the expected cost of the system is funded through contributions either from premiums from beneficiaries or direct contributions from taxation. We do not comment here on any taxation implications or measures driven by the introduction of UHI.

2.11 More detailed costing considerations should include the following:

- Data needs to be captured now and be made publicly available to reduce the uncertainty in the costing of the insurance package given the lack of relevant data currently available; in the short-term, the lack of data may lead to higher premiums being charged.
- Distinguishing between actuarial costing and then how these costs get allocated across different groups in society through contribution rates - the latter being a matter of public policy.
- Strong incentives to manage and control costs, including provider tariffs, maximum pricing tariffs (possibly), careful consideration on the merits of pricing caps, administration costs.
- The impact of cost-sharing mechanisms, including deductibles, co-insurance and capping of benefits under the insurance package.

Regulation (see section 6)

2.12 We see merits in a system of managed competition which relies, as far as is practicable, on the existing frameworks in place, which are intended to facilitate transparent competition or to constrain anti-competitive behaviour. The great strength of the insurance model in principle is that it can be designed to encourage responsible behaviour, e.g. through the use of deductibles. In this regard, incentives can often be more useful than restrictions. It is our view that the system as described in the White Paper would appear to focus more on restrictions.

2.13 In general, we consider that any additional regulation proposed should be the subject of a publicly available cost-benefit analysis. There are a number of additional points of regulation, some potentially quite severe, proposed in the White Paper without reference to a cost-benefit analysis. These include:

- Prescribed Payment Methods
- Price Monitoring
- Maximum Prices for Healthcare Providers
- Imposition of various caps on insurers
- Insolvency fund.

We consider the absence of reference to cost-benefit analyses as a significant omission.

2.14 It is the Society's long held position that risk equalisation is a logical concomitant to a voluntary health insurance system based on community rating, open enrolment and lifetime cover. The principle of risk equalisation being a logical concomitant continues to apply to a universal market, as it reduces the incentive to target preferred risk groups. It is our view that risk equalisation should not be about sharing costs across the market but about ensuring that risks, based upon objectively measureable criteria (such as age or measures of health status, e.g. Diagnostic Related Groups), are shared across the market. We recommend that, in developing a risk equalisation scheme, consideration is given to encouraging insurers to efficiently manage costs and to foster innovation.

General Comments

Transitional Arrangements

2.15 It will be extremely important that adequate transitional arrangements are put in place – not least to ensure the continued viability of an insurance industry that is intended to be a critical part of the system once Universal Health Insurance is in place.

2.16 Two recently-announced initiatives, namely lifetime community rating and permitting discounts for younger insureds, are designed to make health insurance more attractive and more valuable – particularly to younger people. These initiatives should help to sustain the viability of the health insurance market during the run-up to UHI. However, they are not generally consistent with universal health insurance. Evidently, lifetime community rating will not make sense in a universal market, and discounts for younger people are not necessary to incentivise them to join or remain in a universal market.

3 Capital

3.1 The level of regulatory capital required by insurers to operate a UHI system in Ireland will be very substantial. This is an important matter that is not addressed in the White Paper.

3.2 To understand the scale of regulatory capital required for UHI, consider this example. While currently unclear, it is plausible to believe that somewhere in the range of 50%-80% of direct Exchequer spending (€12.8bn for 2014) could be redirected to insurers under UHI. Insurers will be required to set aside regulatory capital for the insurance cover being financed by these monetary flows. The capital requirement under the proposed incoming Solvency II basis may equate to around 25% of the resulting premium flows. These hypothetical assumptions imply an additional capital requirement of the order of €1.6bn - €2.6bn (in 2014 terms). The Society wishes to stress this hypothetical range should not be interpreted as an accurate estimate. Instead, the intent is to highlight the possible scale of the capital requirements involved in introducing UHI into Ireland.

3.3 Obtaining this scale of capital will not be straightforward – e.g. the White Paper highlights the much smaller level of capital currently needed by the VHI to be authorised by the CBI. This scale of regulatory capital will most likely come from a combination of reinsurers, international capital markets and international parent companies of insurers operating in the Irish market. The confidence of these groups in the success and stability of the proposed UHI system will be pivotal in deciding whether such capital will be available and, if so, the return sought to compensate for the perceived commercial risks being taken.

3.4 Insurers will, in practice, pass the cost of this additional capital onto customers through the premiums they charge. This cost of capital is likely to amount to several hundred million euros a year.

Solvency II

3.5 The incoming Solvency II capital system proposes a potential 50%+ reduction in the standard capital basis for health insurers in the case of UHI combined with a risk equalisation scheme – as is proposed in the White Paper. Importantly, a number of pre-conditions must be met before this capital discount can be contemplated. The Society notes the White Paper proposals do generally appear to conform to these pre-conditions. However, the apparent current practice of active ministerial discretion in making yearly changes to the current risk equalisation basis may not be sustainable under the Solvency II pre-conditions.

3.6 Critically, it will be the CBI that will decide what (if any) deductions are appropriate to the standard Solvency II basis for health insurers writing Irish UHI business. Given the substantial potential reduction in the capital requirement and the consequent premium benefit to customers, the Society recommends that the Department of Health liaises and collaborates with the CBI in the detailed design and implementation of the UHI system.

3.7 The actual introduction date for UHI will in practice mean that the business written by health insurers could double or even treble overnight. Clearly, this transformation in the size of insurers' balance sheets is in itself a risk and may require additional temporary capital to be in place – particularly as Solvency II capital reserving methodology requires insurers to consider future business that they know they will write. It would be helpful for CBI guidance on this issue well before the actual introduction date. This point again highlights the need for the Department of Health to liaise and collaborate with the CBI during the development of the UHI system.

Premium Price Caps

3.8 The White Paper proposes that there will be reserve powers to cap insurer profits, expenses, cost of capital and claims. In the context of compelling the public to buy health insurance, it is understandable that the government wishes to reassure people that insurers will not be allowed to make excessive profits. However, the Society believes there are a number of difficulties with this proposal:

i. At a most basic level, this proposal will interfere in the normal competition of the market. The Society notes that no such price caps operate in the compulsory motor insurance market and it is not apparent that insurers make excessive profits in that market.

ii. The proposal gives no guidance on the scale of profitability or expenses that would trigger activation of the price control powers. If it is intended that only a low level of profitability will be tolerated, then in practice this is likely to increase the cost to insurers of obtaining the required regulatory capital (which will be passed onto customers in the form of higher premiums) and may even cause potential capital providers to avoid the proposed UHI market.

iii. Implementing controls on insurers' UHI expenses and profits will be very difficult where insurers operate multiple lines of business.

3.9 Use of loss ratios is an alternative and practical approach to give reassurance that UHI premiums will offer good value for money. Such measures are used in the recently reformed United States health system and are likely to be more transparent to insurers, simpler to administer for the State and more familiar to potential international capital providers.

Potential for increased cost of capital

3.10 The Society recommends that the proposed Healthcare Commissioning Agency give consideration before the UHI launch to publicising the cost levels and usage rates, in summary format, for the various components of the insurance package. In particular, it is likely that several components of the insurance package will not be covered under current health insurance products and health insurers will accordingly lack relevant pricing knowledge. A lack of up-front pricing knowledge on such components would likely represent a material risk factor for capital providers and may also increase the cost of obtaining the required regulatory capital and premiums for policyholders and the State.

Insurance Insolvency Fund

3.11 The existence of an insurance insolvency fund may tend to incentivise insurers to hold lower levels of solvency cover than they would otherwise hold. This anomaly might be corrected by setting the premiums paid to the insurance fund based on the level of solvency cover carried.

Catastrophe Risks

3.12 UHI will expose health insurers to pandemic and mass accident 'catastrophe' risks. Such risks are not substantially covered under current health insurance products (which mainly focus on elective medical procedures only). Solvency II will require health insurers to prudently reserve for such catastrophe-related risks. It may be more efficient for the overall UHI system if health insurers paid a 'best estimate' annual fee to the government in return for indemnity against such catastrophe risks. Such arrangements are in place in many countries in relation to extreme weather-related and earthquake risks. The Society recommends that consideration be given to this idea during UHI's development phase.

4 Benefits

The Basket of Services

4.1 The basket is defined as the healthcare services that will be available to all citizens whether funded through health insurance or directly by the State. It is proposed that the services to be included in the basket will be based on a series of overarching principles as set out in the White Paper. It is also intended that the precise identification of what is to be included will be determined based on comprehensive consultation. It is important that the relevant stakeholders are correctly identified and adequately represented in this consultation, including appropriate representation from the general public. Not least because they will be an important part of financing the basket, our view is that it is imperative that the insurance industry is represented. We recommend that the actuarial profession be separately represented also as actuaries have the skills necessary to assess the financial impact of providing a basket of services to an evolving demographic.

4.2 The tension in creating the basket of services will be between the objectives of providing comprehensive health services and managing the costs (both taxation and compulsory insurance). Difficult questions on how to allocate scarce resources and deal with capacity limitations will need to be answered.

4.3 After the basket has been established, it will be critical that there is an appropriate framework and an agreed basis for making changes. This might follow (for example) the quality-adjusted life-year (QALY) approach used by the National Centre for Pharmacoeconomics (NCPE) in Ireland and the National Institute for Health and Care Excellence (NICE) in the UK. Whichever mechanism is used, it must be transparent and independent of vested interests (although national budgetary constraints will evidently have to be taken into account).

The Insurance Package of Services

4.4 Within the basket of health services, a sub-set will be paid for by compulsory insurance. A key task will be to determine which services within the basket should be a part of the insurance package. There does not appear to be a clear identification in the White Paper of which services would be in the insurance package. The supplementary Background Policy Paper[1] states that public health services do not necessarily align well with the decentralised, individualised focus of insurance. Where responsibility for funding services such as screening and immunisation is shifted to insurers, the fact that insurers are not incentivised to promote and pay for the services may lead to lower usage of those services, contrary to the interests of society as a whole. This should be taken into account in determining which services should be included in the insurance package of services.

4.5 While budgetary and cost constraints will be important in determining the initial and ongoing content of the insurance package of health services, it will also be important that the package does not come to be viewed as a means of controlling the national health budget. We recommend that the inclusion of services in the package is based on agreed values and principles, and assessed independently through a transparent process, to ensure that decision-making is subject to appropriate parameters and that, for example, insurance packages are not used inappropriately as a mechanism for transfer of costs from central health spending.

[1] http://health.gov.ie/wp-content/uploads/2014/04/Background-Policy-Paper-on-Designing-the-Future-Health-Basket.pdf

4.6 It appears that a reason for including some items (such as acute hospital care) in the insurance package is so that insurance companies will negotiate with providers, i.e. to create a competitive tension that will optimise efficiency and value to the ultimate consumers. This is rational but it will be important that both insurers and providers have sufficient competitive freedom in order to be able to negotiate. For example, insurers should be free to include or exclude providers in coverage and providers equally should be free to accept or decline the terms offered by insurers. In practice, it might be necessary to limit/control this freedom somewhat – for example, in order that insurance meets minimum standards, including in respect of access to geographically convenient services.

4.7 The White Paper makes the point that some services, notably accident and emergency, are continuously available to the public regardless of the level of use. Hence it is proposed that such services be paid for on the basis of a levy on each insured person, rather than on a usage basis. While it is logical that such services are (at least partially) paid for from a general pool, it does not necessarily make sense that such services should be funded from the insurance premium. It may be more efficient if these services are funded from general taxation. At a minimum, inclusion of such benefits in the insurance package will generate an additional capital cost that will be passed on through premiums; accordingly, the aggregate cost of passing the levy through insurance premiums will be greater than if it were funded through general taxation.

4.8 It will be important that changes to the insurance package are orderly and consistent in order to allow insurance companies to plan, set premium rates and set reserves.

4.9 The White Paper states that minimum and maximum co-payments will apply. The need for minimum co-payments on a statutory basis is not clear (although there are good reasons why insurance companies will choose to apply co-payments). It is also unclear how larger co-payments will function in situations where insured people who do not have the means to pay insurance premiums are faced with such co-payment charges. It might be appropriate that for some parts of the population, the State will fund co-payments.

4.10 It is suggested that GP and some other primary services will be included in the insurance package. While the Society does acknowledge that there may be structural and clinical benefits from having the payment of primary care and hospital care handled by a common payer, it is not clear how it is intended that payment for GP services will be managed. GPs are currently paid for out of pocket or through the General Medical Services (GMS) scheme on a capitation basis. Where covered by insurance, this coverage is typically on a reimbursement basis for a part of the cost. If there is to be a single tier for access to primary care, it is likely that the optimal approach will be a capitation basis with a co-payment at point of service. It is difficult to see how or why it would be sensible to include a capitation benefit as part of the insurance package as it is unclear how competition could drive down these costs.

The Role of Insurance Companies

4.11 Key factors in the successful implementation of UHI will be insurers' ability to operate efficiently and obtain competitive rates from providers – notably hospitals. As well as efficiency of operation, healthy competition will be required – and the market will require the participation of a number of insurance companies to be viable.

4.12 It is important to consider the means by which insurance companies will be able to compete. Based on the proposals within the White Paper the potential dimensions for competition seem to be:

- Level of co-payment (within specified limits)
- Provider networks
- Price competition.

It is difficult to understand how, if insurers offer different networks of providers, a single tier can be offered, as access times are likely to vary by provider (and hence by insurance product / insurer).

4.13 In relation to price competition, this will translate into seeking efficiencies in claims and in expenses. Claims rate competition will rely on building provider networks with competitive rates. Expense competition will be based on seeking efficiencies in operations. Under both headings, larger insurers will tend to have advantage and smaller insurers may not be viable or may need to seek alternative means of competition.

4.14 It is not clear whether insurers will be permitted to offer insurance policies on a reimbursement rather than a direct payment basis. Permitting both types of insurance would allow a different dimension to competition but may also add complexity to consumer protection and other regulation

4.15 It is not clear how a single tier can operate in the context of differing networks and (potentially) different levels of accommodation being offered. Solutions that leave unused capacity would be less than optimal in terms of efficiency while systems that do not allow differentiation of hospitals or rooms would appear to prohibit private hospitals from recouping the costs of more expensive facilities. In addition, persistently unused capacity will eventually have to be closed down.

4.16 Consideration should also be given to how changes in insurance cover are to be managed if insurers are to be permitted to offer different levels of benefit (through co-payments) or different networks of providers. It will not be reasonable to expect that the insured will be permitted to acquire the lowest level of coverage and upgrade without penalty in the event that a higher level of service is sought.

4.17 It is proposed in the White Paper that the HIA will recommend an "Efficient Market Rate". This rate will represent the reasonable average premium of an efficient insurer. As this rate will be the rate that the State (through the National Insurance Fund) will pay for insurance, the rate should be determined based on expected claims for the population paid for by the State. It is likely that this premium will be higher than would apply to the population as a whole. This is because those who have their care paid for by the State (generally due to lower income levels) typically have a higher level of usage of health services. If the rate is set too low, there is a significant danger that no insurer will offer insurance at this rate and it is unclear what the next resort of the State will be in purchasing insurance (assuming the insured whose premium is paid will not be able to or wish to make up the difference).

Moral Hazard

4.18 One of the key principles underpinning insurance is avoidance of moral hazard. The existence of moral hazard will always tend to drive up insurance premiums. There are several potential sources of moral hazard in the proposed system that need to be carefully considered, including:

i. A person visiting a GP unnecessarily because such a visit is free. This wastes the resource of the GP's time and costs the insurer money, which ultimately increases premiums. This might be addressed through co-payments, for example.

ii. A person choosing an insurance policy at the lowest cost without consideration of the benefits on the basis that he or she can change the plan to a higher cost plan with greater benefits (e.g. wider hospital coverage, lower excess) without penalty at any time in the future in the event that making a claim is anticipated. This will tend to increase premiums for all. This might be addressed by allowing underwriting restrictions as people change their levels of cover.

Supplementary Insurance

4.19 It seems likely that a vibrant competitive market for supplementary insurance will be important in making the basic insurance market attractive to a sufficient number of players to ensure that it can be an efficient market.

4.20 If it is considered desirable that there is a vibrant market for supplementary insurance (and arguably this may be necessary for the basic insurance market to be sufficiently attractive to a sufficient number of insurance companies), it will be necessary to allow some insurable benefits to exist outside the basket. On the other hand, it will be important that the operation of the supplementary benefits does not undermine the principles underpinning the basket. This does not appear to be consistent with the policy direction where it is envisaged that upgraded accommodation, for example, will sit outside the basket.

4.21 We note that it is expected that this supplementary market will be risk-rated. This may be seen as unfair by those who have paid community rates for relatively high levels of cover, including benefits that will likely be part of supplementary cover, for years or decades. This perceived unfairness may be minimised if the standard insurance package is comprehensive. However, if the benefits under the insurance package are very basic, then a large number of people may take out supplementary insurance, in which case risk-rating might be against the core principles of UHI.

4.22 The scope for supplementary insurance seems to be primarily:

- Services not intended to be in the basket including alternative therapies, cosmetic surgery.
- Faster access to items that are in the basket but not in the insurance package.
- Upgraded settings (e.g. private room, better food, etc).
- Access to healthcare outside the State.
- Cover for providers within the State who remain outside UHI.

4.23 The existence of supplementary cover may be an impediment to there being a true single tier. For example, it will be difficult to maintain a single tier when a subsection of the insured population has coverage for some accommodation that is not accessible by other insured individuals.

4.24 Travel for cover in other jurisdictions is likely to arise, in particular if those who are currently insured experience longer waiting times than at present and do not find this acceptable. The more that health care is rationed within the system (i.e. within the basket), the more likely it is that some people will pay for overseas care (directly or through supplementary insurance).

4.25 Depending on regulations and the system of accreditation, it is possible that some providers (notably private hospitals and consultants) may choose to "opt out" of Universal Health Insurance and will only be accessible through direct payment or supplementary insurance.

5 Costing

5.1 The cost of delivery of both the insurance package and the overall basket of services will be a key issue under the UHI system. Clearly it will affect the financial sustainability of the UHI model but it will also affect confidence in the UHI project as a whole.

5.2 A number of factors will influence the cost of UHI. These include:

i. The scope and range of services provided under the insurance package will be one of the key determinants of the overall cost of UHI - the more comprehensive the insurance package aims to be, the more expensive the cost.

ii. The overall health profile of the population.

iii. The level of cost-sharing within the system, including the use of deductibles and co-payments.

5.3 The White Paper is based upon the premise that the key to an efficient system is managed competition between all providers, including all public and private providers. Currently there is no competition with or between public providers. However, it seems unrealistic that competing insurers alone (particularly in geographical areas outside of Dublin and, possibly, Cork) will stimulate such competition in the short to medium term.

Principles for costing

5.4 We believe that, in order that managed competition can be effective in controlling costs, the following principles for costing are important:

i. The UHI system should create incentives for competition between providers and insurers that will encourage the most efficient use of health care.

ii. The practicalities of pricing and consumer protection need to be taken into account. For example, given the nature of healthcare, we believe that costing should be undertaken on a one-year funded basis and, thus, premiums should be set annually.

iii. The system should be self-funded insofar as the expected cost of the system is funded through contributions either from premiums from beneficiaries or direct contributions from taxation. We do not comment here on any taxation implications or measures driven by the introduction of UHI.

Data considerations

5.5 It is important to understand that there may be limitations to the data available for costing purposes either because no such data exists or the data does not capture credibly the likely risk profile of beneficiaries. This potentially will result in considerable uncertainty in the costing of the insurance package and it may lead to insurers adding an additional margin to the underlying costing until better data emerges. Full transparency of the pricing models to be developed by the proposed Healthcare Pricing Office in the run-up to the introduction of UHI could go a long way to mitigating this risk.

5.6 The determination of the appropriate costs under UHI will be a complex calculation and will involve a detailed analysis and review of all prospective costs within the system. This will involve a review of data from many sources including data from existing insurers, medical providers and demographic information from central sources such as the census. Insurers may be able to contribute data to policy formulation, since they are a source of reliable claims experience at the level of the individual insured.

Scope of costing

5.7 A key aspect to determining appropriate costing for any health insurance package, be it the UHI package or otherwise, is to have a defined set of benefits that will be paid in a defined set of circumstances. In this regard, we believe that the scope of the UHI basket of services should only extend to services for medically necessary treatment provided by a registered health provider.

Distinguishing between costing and contribution setting

5.8 It is important to distinguish between the costing of UHI and the determination of the contribution levels between different groups.

5.9 Any actuarial costing simply refers to the projection of the expected costs involved in providing a defined basket of services. The setting of contribution rates divides the expected cost of provision of the basket of services between different groups in society. It will mean that there will be cross-subsidies between certain risk groups (e.g. between the old and young, the healthy and the sick). The determination of the cross-subsidies to apply is a matter of public policy.

Cost management

5.10 Crucial to the success of UHI will be to ensure that there are sufficient incentives within the system to manage and control costs. In this regard, we consider a number of possible approaches that could be used to manage costs.

Provider tariffs

5.11 To manage costs, it may be effective to put new care delivery models in place that will incentivise delivery of care in more cost-effective settings than currently is the case (e.g. through primary care rather than more expensive hospital care). Having a single commissioning body for care may be a mechanism for achieving this in the short-term in order to foster competition between different provider groups.

Maximum pricing tariffs

5.12 The use of maximum pricing tariffs needs to be carefully considered; their effect on costs is unclear. For example, their use could lead to an increase in costs as these maximum tariffs could also become minimum tariffs for each procedure/consultation. On the other hand, in a competitive market, insurers should be trying to reduce these costs in order to gain an advantage, and in that context, a maximum tariff could act as a starting point for downward price negotiations and could therefore have a positive benefit.

Administration costs

5.13 We recognise that as part of any introduction of UHI, insurers should be encouraged to manage their administration costs. However, it is not clear that imposition of administration cost caps will be more effective than normal competition in managing administration costs. It is also difficult to see how such caps could be imposed in practice – particularly for multi-line and multi-territory insurance businesses. It is also the case that any administration caps would need to allow for increases in costs associated with the scaling of business, particularly in the early years of UHI.

5.14 In order to manage the administration costs within the system, consideration should be given to sharing of costs across the industry where there is no competitive issue, e.g. related to the central registration of the currently uninsured group in the population.

Cost sharing

5.15 A number of different cost-sharing mechanisms could be put in place to manage the expected cost of delivery of UHI. These include the use of deductibles, co-insurance and the capping of the benefit to be paid under the insurance package.

5.16 The extent of the use of these different mechanisms is, in part, a matter of public policy. The extent to which they are successful in reducing costs will depend upon the nature of benefits to which they apply and the level of cost-sharing used. For example, having a given deductible may reduce the utilisation of general practitioner services while having no impact (for good reason) on utilisation of high cost services relating to catastrophic medical diagnoses.

5.17 There is an issue of equity associated with the use of such cost-sharing mechanisms as they should not be used as an obstacle for those who really need to receive care from a medical perspective gaining access to it.

5.18 Insurance packages will vary by co-payments and healthcare service providers. This provides insurers with a number of options. However, it will be important that policyholders understand the level of co-payments that are available on their products. It should be noted that scope exists for insurers to use co-payments as a tool to target the most attractive risks (e.g. by applying a high level of co-payments for particular treatments).

Managing the cost through phased introduction of UHI

5.19 We believe that consideration should be given to the phased introduction of UHI as this could potentially limit the cost and bring greater certainty to the introduction of UHI.

Other considerations

The costing basis

5.20 As indicated above, we support a one-year funded system of community rating that has long been the cornerstone of the voluntary health insurance market as being the basis for costing within the market.

New immigrants

5.21 Related to cost management is the treatment of new immigrants. It will be necessary to determine whether new immigrants will be required to take out health insurance or if they will be covered by the Compensation Fund until they purchase a UHI policy. While the EU Directive on Patients' Rights in Cross-Border Healthcare addresses citizens of the EU, our understanding is that there is no mechanism to cover the cost of non-EU citizens and this needs to be considered in terms of costing the UHI package.

Treatment outside Republic of Ireland

5.22 It may be possible for insurers to procure services for their members in other jurisdictions at a cheaper cost than in the Republic of Ireland. From a cost point of view, this may, all other things being equal, reduce the cost of provision of the UHI package. However, it needs to considered, also, in the context of not compromising access to and the quality of services provided for the insured population. In particular, we draw attention to the issue of treatment being provided in Northern Ireland for individuals near the border counties, which we believe should be allowed.

6 Regulation

6.1 From a regulatory perspective, there are a number of areas covered in the White Paper - specifically:

- General regulation of the market
- Risk Equalisation
- The Insolvency Fund
- Cost Control measures.

We consider each of these topics below.

General regulation of the market

6.2 There are merits in a system of managed competition which relies, as far as is practicable, on the existing frameworks in place, which are intended to facilitate transparent competition or to constrain anti-competitive behaviour. The great strength of the insurance model in principle is that it can be designed to encourage responsible behaviour, e.g. through the use of deductibles. In this regard, incentives can often be more useful than restrictions. It is our view that the system as described in the White Paper would appear to focus more on restrictions.

6.3 Well established principles of intelligent regulation would suggest that any additional regulation should be the subject of publicly exposed cost benefit analysis. There are a number of additional points of regulation, some potentially quite severe, being proposed in the White Paper, and yet there is no reference made to any cost-benefit analysis which has taken place.

6.4 Under UHI, the current structure of two regulators would continue. The Health Insurance Authority (HIA) will retain a central role in terms of general regulation of the market. We note that many of the activities set out under this heading are similar to those currently discharged by the HIA in the voluntary market. In addition, the CBI will continue to have responsibilities in relation to the regulation of insurers and intermediaries.

6.5 Where the HIA must discharge additional responsibilities under UHI relative to those currently discharged (for example, analysis required in respect of the efficient market rate), and in light of the expected difference in the scale of the UHI market relative to the scale of the current voluntary market, it would be important to consider whether the resources and skillset of the HIA are sufficient to discharge those responsibilities. Any increase in resources required should form a consideration of the cost-benefit analysis described above.

6.6 In the run-up to the introduction of UHI, a health insurance market which is viable will improve the likelihood of UHI being successful. We would encourage that measures be introduced to address the sustainability of the market in the interim, which may include the recently announced initiatives of lifetime community rating and discounts for young adults. We acknowledge, however, that once the insurance becomes mandatory, these particular measures will not be required.

Risk Equalisation

6.7 It is the Society's long held position that risk equalisation is a logical concomitant to a voluntary health insurance system based on community rating, open enrolment and lifetime cover. The Society has also previously stated that, given the structure of the Irish market, it would be reasonable for the form of a risk equalisation scheme to encourage competition and new competing insurers. Evidently, the introduction of universal insurance fundamentally changes the structure of the market. The principle of risk equalisation being a logical concomitant continues to apply to a universal market as it reduces the incentive to target preferred risk groups. However, note that the impact of the nature and extent of risk equalisation on the market and on competition in the transition phase and after the introduction of universal health insurance will need very careful consideration and management.

6.8 It is our view that risk equalisation should not be about sharing costs across the market. It should be about ensuring that risks, based upon objectively measureable criteria (such as age or measures of health status, e.g. Diagnostic Related Groups) are shared across the market. We recommend that, in developing a risk equalisation scheme, consideration is given to encouraging insurers to efficiently manage claims and to also foster innovation.

6.9 We note that the availability of robust and reliable data may be a challenge in relation to the development of an appropriate risk equalisation scheme. This challenge may be more significant immediately following the introduction of UHI due to the large shifts in underlying data. Again, full transparency of the pricing models to be developed by the proposed Healthcare Pricing Office in the run-up to the introduction of UHI could go a long way to mitigating this risk.

Insolvency Fund

6.10 The White Paper envisages "a third major task in relation to regulation of the health insurance industry" in respect of the management of an Insolvency Fund. The White Paper does not provide detail in relation to the operation of this fund, or where regulatory responsibility for the fund will lie. We believe that further clarity would be required in relation to this fund, including how it would operate for a multi-line insurer.

Cost Control Measures

6.11 We support the proposal that individual insurers should retain the ability to negotiate costs. This, we believe, enhances competition in the market place. It would be helpful to provide clarity that, in negotiating contracts with healthcare providers, insurers will have the freedom to include contractual requirements that will enable them to control the level of utilisation of healthcare services. This would help ensure that limited resources can be allocated based on need and quality of care, and thereby help control costs.

Price Monitoring

6.12 As drafted, it is hard to see this having a significant impact on reducing premiums, but it would potentially require a significant increase to regulatory overheads, which would in turn be reflected in policyholder premiums.

Setting Maximum Prices for Healthcare Providers

6.13 We acknowledge that transitional arrangements have been considered in setting up a new Healthcare Commissioning Agency with responsibility for purchasing healthcare services.

6.14 We would note that the costs associated with lengthy negotiation processes may be significant as providers may need to deal with a number of insurers and insurers with a large number of providers. We would recognise the importance of there being sufficient flexibility to ensure new procedures, technology, drugs etc. are included.

6.15 The White Paper does not make it clear whether insurers may be free to set up agreements with a limited number of providers in order to offer a lower cost insurance package that only covers certain hospitals. If this were permitted it would appear to conflict with some of the high level principles of UHI.

6.16 Under the EU Directive on Patients' Rights in Cross-Border Healthcare, the cost of a policyholder's medical treatment in other EU countries would need to be covered. The cost for specific services in other EU countries may exceed the maximum prices set according to the contracts with Irish providers. This is an area of claim cost that will be difficult to control.

6.17 Some services will fall outside UHI and be covered by the state. In order to ensure fairness between providers of UHI benefits and state covered benefits, there needs to be a similar level of cost control in place for these services.

Reserve Measures

6.18 Regulatory measures that may result in insurers reducing their efforts towards efficient claims management could become counterproductive. This may be the case when overheads are capped, as investment may be required to deliver effective cost containment. We would question the meaning of the caps on claims costs in particular. What does this mean in the case where a treatment is needed but the insurer has already reached its cap in that period? What is the impact on the insured population; will there be the same access to care for all insureds no matter what insurance company is providing the policy (when considering plans with the same coverage levels)? Is it envisaged that some system of pre- authorisation would be mandatory for this model? Potentially this measure could undermine the principle that access to care should be based on need, as it may also introduce an additional dimension whereby access to care depends on where the insurer is in relation to its cap.

6.19 We would question whether the specific reserve measures proposed in the White Paper would act as a barrier to either entry to, or continuation in, the health insurance market. The idea of managed competition is that price competition will ensure that efficient insurers survive and prices are driven down. It is unclear whether the measures proposed are the most effective way to achieve this objective.

7 Queries

We would be delighted to assist if clarification or elaboration is required on any of the points made in this submission. Please direct any queries to Ms Yvonne Lynch, Director of Professional Affairs, at the contact details at the end of this submission.

8 Appendix: Consultation Questions

In responding to the White Paper, we have focussed on four themes: Capital, Benefits, Costing and Regulation.

We provide cross-references below to sections of our response that are relevant to specific questions raised in the Consultation on the White Paper. Where no cross-reference is given, this means that the question is not addressed in our response.

3 Proposed Organisation & Delivery of the UHI Model

3.1 When the UHI system is in place, health insurers will be responsible for purchasing care on behalf of the population. Do you have any views on safeguards that should be built into this system, e.g. timely access to care, geographic limits etc.?

See paragraphs 4.1 to 4.3, 4.4 to 4.6, 4.9, 4.11, 4.15 to 4.17

3.2 Do you have any views on the role of the National Insurance Fund in (a) directly financing certain services and (b) being responsible for the financial support payments system?

3.3 How, in your view, can integration between health services outside of UHI and those in the standard UHI package best be achieved?

See paragraphs 4.1, 4.4 to 4.10, 4.14, 4.16, 4.17, 4.22, 4.23

3.4 What should be the priorities for phasing the delivery of the UHI model i.e. with full implementation by 2019?

See paragraph 2.16

3.5 Do you have any views on the role of supplementary insurance under the new system?

See paragraphs 4.19 to 4.25

3.6 The White Paper sets out a proposed values framework to guide the work of the Commission in assessing what services should be included under UHI and the overall health system. Do you have any views on this values framework?

See paragraphs 4.1 to 4.3

4 Policy & Operational Aspects of the Subsidy System

4.1 Do you have any views on how the subsidy system for UHI should operate i.e. how can we ensure that it protects those on low incomes?

4.2 The White Paper notes that the financial subsidy system will be provided on a means tested basis. Do you have any views on whether this assessment should be solely based on income or if other factors such as assets should also be included?

4.3 Some members of the population currently have entitlements under various schemes e.g. medical cards, GP visit cards, Long term illness scheme etc. Do you have any views on how these benefits may best be delivered when UHI is introduced?

5 Regulation of Healthcare Providers & Purchasers

5.1 Do you have any views on the proposed system of regulation of healthcare providers and health insurers? Are there any areas you would like to see strengthened?

See:

- Paragraphs 3.8, 3.9, 3.11, 4.11 to 4.17
- Section 6

5.2 Do you have any views on how the management of contractual disputes regarding health insurance might be best achieved?

5.3 Do you have any views on what economic regulation mechanisms should be applied to ensure good governance and financial management of health services?

6 Financing of UHI and the Overall Health System

6.1 Do you have any views on the proposed new financing model for UHI i.e. a blend of premium income, direct taxation and out of pocket payments?

See paragraph 4.5

6.2 Do you have any views on the use of co-payments for services?

See:
- Paragraphs 4.9, 4.16, 4.18
- Section 5

6.3 Do you have any views on the cost control measures that have been set out in the White Paper? Are there other cost control measures that could be implemented?

See:
- Paragraphs 3.8 and 3.9
- Section 5
- Paragraphs 6.11 to 6.19

6.4 In your view, how best can the regulatory systems set out in the White Paper provide the State with sufficient means to safeguard the financial sustainability of the health system and secure ongoing affordability of UHI policy premiums?

See:
- Section 5
- Section 6

6.5 Do you have any views on how the regulatory and administration costs of the system might be minimised?

See:
- Paragraphs 3.5 to 3.6
- Section 5
- Section 6

7 Additional Comments / Observations

Should you wish to provide comments on any other aspects of the White Paper please do so in the box below or attach a document in the email response.

See full response, in which we focus on the following four themes: Capital, Benefits, Costing and Regulation.

Society of Actuaries in Ireland, Clanwilliam House, Clanwilliam Place, Dublin 2

tel: +353 1 634 0020 | **fax:** +353 1 634 0039 | **web:** www.actuaries.ie

Registered in Dublin as a Company Limited by Guarantee No.146024. Registered Office: Clanwilliam House, Clanwilliam Place, Dublin 2, Ireland