THE HEALTH INSURANCE AUTHORITY

Consultation Paper

Minimum Benefits

October 2003

1. Introduction and Purpose

In the White Paper on Private Health Insurance, issued in 1999 ("the White Paper"), the Government indicated its intention to amend the current system of minimum benefits, as specified in the Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 (SI No. 83 of 1996). Included in the amendments is a proposal to give The Health Insurance Authority a greater role in relation to minimum benefits.

The Health Insurance Authority ("the Authority") is currently formulating its position on minimum benefits and is seeking representations on issues relating to this matter from stakeholders and interested parties.

The content of this paper is as follows: Section 2 sets out some brief background on minimum benefits, including the current system and the changes proposed by the Government; Section 3 outlines some of the issues relating to such a move and includes a suggested list of topics to be covered in responses to this consultation paper. Stakeholders are invited to address any or all of these topics, or any other relevant matters.

Please submit two hard copies, or one electronic copy, of any response by Friday, 19 December 2003 to:

Mr Dermot Ryan
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The Health Insurance Authority
Canal House
Canal Road
Dublin 6

E-mail: DermotRyan@hia.ie

Please note that the Authority intends to make all of the responses to this consultation paper publicly available.

2. Background to Minimum Benefits

The key purposes of the minimum benefit system, as outlined in the White Paper, are:

- "to maintain inter-generational solidarity within the community rating system;
- to ensure the continued availability of the type of broad hospital care cover traditionally held as a minimum by the insured population;
- to ensure that individuals do not significantly under-insure due to lack of proper understanding of the restrictions which, in the absence of a specified minimum entitlement, could apply to some types of policies."

The rationale behind minimum benefits supporting inter-generational solidarity is that the specification of minimum benefits means that private health insurers are not able to design plans that would appeal to low-risk groups, as to do so could lead to the segmentation of risks and result in more comprehensive plans - which would attract high-risk groups - costing more. This would be against the spirit of community rating.

Within the minimum benefits structure, insurers have scope to determine whether benefits paid should be based on treatment performed on an in-patient, day-patient or outpatient basis. Insurers may also specify the healthcare providers whose services are covered, allowing for the creation of preferred provider networks, which have the potential for cost-containment.

The existing minimum benefit regulations comprise detailed schedules of medical procedures and prescribed minimum payments for each of these. The regulations cover in-patient services, day-patient services, outpatient services and certain other health services provided by a hospital consultant, whether in a hospital setting or otherwise.

The changes proposed by the Government in the White Paper centre around a simplification of the existing extensive schedules. One such proposed change would, under certain circumstances, give The Health Insurance Authority discretion to determine some minimum reimbursement rates by insurers for procedures carried out by consultants not in fully participating agreement with insurers. Further details on the proposals can be found in Chapter 5 of the White Paper on Private Health Insurance, 1999.

3. Issues Relating to the Proposed Changes

The changes to the minimum benefit regulations proposed in the White Paper raise a number of issues, some of which are outlined below.

Role of The Health Insurance Authority

The Health Insurance Authority would, under the changes proposed, have a greater role to play than currently in determining the appropriate level of minimum benefits and reimbursement levels.

What is an appropriate balance between prescriptive schedules and the discretion of the Authority? To what extent should the Authority be responsible for determining minimum benefits and reimbursement rates? What, if any, clinical expertise would need to be drawn on in the fulfilment of this role?

Review of Minimum Benefits

In many cases, the existing minimum benefit schedule, which was adopted in 1996, specifies monetary amounts of cover, which constitute the minimum reimbursement rates for various procedures. Since 1996, medical inflation has been significant, and therefore these monetary amounts now represent relatively lower levels of reimbursement for the relevant procedures.

Should any revised minimum benefits be inflation-linked? If so, what measure of inflation should be used? Alternatively, should the minimum benefits levels be reviewed on a regular basis? If so, how regularly should this review take place? Should minimum benefit reimbursement rates be set in non-monetary terms? If so, what measures should be used?

Scope of Minimum Benefit Regulations

The minimum benefit regulations adopted in 1996 did not apply to health insurance contracts that provided solely for ancillary health services. The Health Insurance (Amendment) Act, 2001 specifies that health insurance contracts that provide solely for relevant health services (a narrower definition than ancillary health services) should not be subject to the minimum benefit regulations.

Are these exemptions from the minimum benefit regulations appropriate? Should separate minimum benefits be applicable to health insurance contracts covering solely relevant health services? Are there any other types of health insurance contracts that should be exempt from the regulations?

4. Queries

Any queries on this paper, in advance of submissions, may be directed to Brian Turner, Head of Research/Technical Services, who can be contacted by telephone on (01) 406 0080 or by e-mail at BrianTurner@hia.ie.