THE HEALTH INSURANCE AUTHORITY

An tÚdarás Árachas Sláinte

Report to the Minister for Health and Children on Minimum Benefit Regulations in the Irish Private Health Insurance Market

December, 2010

Table of Contents

Section 1 - Introduction 2
Section 2 – Summary of Recommendations 4
Section 3 - Background to Minimum Benefit Regulations 6
Section 4 - Submissions Received 7
Section 5 - Public and Private Hospitals 8
Section 6 - Updating and Simplifying the Regulations 12
Section 7 - Primary Care and Chronic Disease Management 14
Section 8 - Supporting Community Rating 19
Section 9 - Other issues 20

Section 1 - Introduction

The Health Insurance Authority

The Authority is a statutory regulator for the Irish private health insurance market. It was established in 2001 under the Health Insurance Acts 1994 to 2009. The principal functions of the Authority as provided for in the Health Insurance Acts include the following:

- to monitor the health insurance market and to advise the Minister for Health and Children ("the Minister"), either at his or her request or on its own initiative on matters relating to health insurance;
- to monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts;
- to carry out certain functions in relation to health insurance stamp duty and age related tax credits and in relation to any risk equalisation scheme that may be introduced;
- to take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
- to maintain the "Register of Health Benefit Undertakings" and the "Register of Health Insurance Contracts".

The Consultation Process

On 8 June 2010, the Minister asked the Health Insurance Authority to consult with stakeholders in relation to minimum benefits to be provided by insurers.

In July, the Authority published its Consultation Paper in relation to a review of the existing Minimum Benefit Regulations. The Consultation Paper was advertised in the national press and interested parties were invited to make submissions. In September, the Authority received 13 submissions to the process. The Consultation Paper and the submissions can be viewed on the Authority's website at www.hia.ie.

Having regard to the Government's guidelines on regulatory impact analysis, the Consultation Paper set out the policy context for the Minimum Benefit Regulations and stated the objectives of the Regulations. The Paper also identified and analysed a number of options for Minimum Benefit Regulations and requested contributions in relation to necessity, proportionality, effectiveness, accountability, consistency and transparency. This Report, particularly in Section 5 to 9, considers the costs, benefits and impacts of various different options for Minimum Benefits, having regard to the submissions received.

The Report

This Report contains a brief background discussion on minimum benefits and relevant aspects of the health insurance system. A summary description of the current Minimum Benefit Regulations is followed by an outline of the issues considered in the consultation and the Authority's recommendations in relation to these issues.

Section 2 – Summary of Recommendations

Public and Private hospitals
Minimum Benefit Regulations should maintain the distinction between public and private hospitals. The Regulations should require that products providing cover for in-patient hospital care cover all public hospitals for the full hospital charge for treatment in a semi - private bed, including the daily statutory charge. Article 9, which allows insurers selectivity as to which private hospitals they cover, should remain.

Updating the Schedules
Maintain schedules in the Regulations detailing the minimum benefit levels for specific healthcare services, but update the schedules, having regard to expert medical advice, insurers' current levels of allowable charges and the lower end of the range of costs for healthcare services currently applying in the market. In general, minimum benefit levels should be set somewhat below the current market levels.

There should be provision for a periodic review of the schedules.

Long term hospital stays
In respect of long term hospital stays, Minimum Benefit Regulations should provide for the following:

- A lower minimum payment for hospital stays longer than 100 days.
- A sliding rate for hospital consultant's daily benefit for longer inpatient stays.

Primary Care – Chronic Disease Management
Minimum Benefit Regulations should include a list of chronic diseases, each with an associated prescribed level of minimum primary care benefit. Those diagnosed with the chronic disease would be entitled to receive the prescribed benefit. The benefit would include cover for a set number of consultations with suitably qualified healthcare professionals (up to a fixed monetary cost per consultation) as well as cover for part of any cost of prescription medicine not recoverable from a state Scheme.

The list of chronic diseases and the associated prescribed benefit levels should be determined having regard to expert medical advice.

Community Rating
Monitor the impact of changes to the risk equalisation system in order to assess how successful the amended system is in addressing risk segmentation strategies. If there continues to be an increase in the extent to which product design is used to segment the market then consider amending the Minimum Benefit Regulations to prohibit insurers from offering different levels of cover for different treatments within the

same hospital (subject to prescribed exceptions, such as where a hospital provides a national specialty).

Psychiatric Illness
There should be no distinction in the Regulations between psychiatric and other conditions as regards the number of days for which treatment must be covered.

Section 3 - Background to Minimum Benefit Regulations

The 1996 Minimum Benefit Regulations

Section 10 of the Health Insurance Act 1994 (as amended) ("the Act") provides for minimum benefits and for the Minister making Minimum Benefit Regulations. Minimum Benefit Regulations were introduced in 1996[1] and continue to apply, the only amendment in the intervening period being a technical amendment in 2005[2].

The Regulations cover in-patient, out-patient and day-patient services provided by publicly funded hospitals, private hospitals, registered nursing homes and hospital consultants. Services provided by other healthcare providers are not included in the Regulations.

Primary care treatment is not covered by the Minimum Benefit Regulations unless it is out-patient treatment provided by a hospital or hospital consultant. Under the Regulations, an insurer may also limit the total of payments for out-patient services to a maximum of €829 in any one year.

Four schedules to the Regulations specify the monetary amounts of prescribed minimum payments, including lists of minimum benefit for specific procedures. The four schedules relate to the following:

Schedule A – Hospital Charges (in-patient and day-patient)

Schedule B – Special Procedures

Schedule C – Consultant's Fees (in-patient and day-patient)

Schedule D – Out-patient

Payments are specified differently for public and private hospitals.

Under the current Minimum Benefit Regulations, insurers have some scope to determine, on the basis of medical advice, whether benefits paid should be based on treatment performed on an in-patient, day-patient or out-patient basis. Insurers may also specify the healthcare providers whose services are covered.

[1] S.I. No. 83/1996 – Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996 http://www.irishstatutebook.ie/1996/en/si/0083.html

[2] S.I. No. 333/2005 – Health Insurance Act, 1994 (Minimum Benefit) (Amendment) Regulations, 1996 - http://www.irishstatutebook.ie/2005/en/si/0333.html

Section 4 - Submissions Received

The Authority received 13 submissions to its Consultation Paper from the following parties:

Aviva Health
Beacon Medical Group
Consumers Association of Ireland
Hospital Saturday Fund HSF
Irish Medical Organisation
Irish Society of Chartered Physiotherapists
Major RMU's: ESB SMPF, St. Paul's Garda, Prison Officers Medical
Quinn Healthcare
St. Patrick's University Hospital
Society of Actuaries in Ireland
Dr. Brian Turner, University College Cork
Vhi Healthcare
VHI's Members Advisory Council

The submissions are available on the Authority's website at www.hia.ie.

The Authority wishes to thank all those who contributed to the process.

Section 5 - Public and Private Hospitals

Need for Review

When the current Minimum Benefits Regulations were made, there were fewer private hospitals and most elective treatment was carried out in designated private beds in public hospitals. The Regulations oblige insurers to provide cover for the full hospital charge (determined by the Minister) for treatment in a semi-private bed in publicly funded hospitals that. This charge has increased very significantly since 1996. In contrast, there has been no updating of the minimum insurance cover in a private hospital since 1996.

Since 1996, important developments have changed the policy circumstances substantially. A number of new hospitals have opened in the last ten years. In the context of developments in healthcare and in the context of rapid growth in population, employment and real incomes, demand for hospital capacity for elective treatment has increased substantially and is being mainly paid for by claims on health insurance. This has resulted in insurance payments to private hospitals rising rapidly and now broadly equalling payments to public hospitals. Another important development in recent years is the much changed context of private treatment in public hospitals. The Health Services (In-Patient) Regulations, 1991, designates approximately 20% of beds in public hospitals as private beds, even though 50% of the population now has private health insurance. In addition, private patients admitted on an elective basis to a public hospital cannot be accommodated in a designated public bed. The stricter enforcement of these rules, coupled with the growth in the population with health insurance but with a relatively static private bed capacity in public hospitals, has resulted in a substantial increase in the proportion of private elective operations being carried out in private hospitals.

Consequently, since 1996, there has been a significant change in the proportion of private healthcare provided in private hospitals rather than public hospitals. This change may continue in view of the increase in the number of private hospitals, the new “public only” consultants contracts etc.

Also, as noted earlier, the terms of the Regulations relate differently to private treatment in public hospitals (where the full cost of accommodation in a semi-private bed must be covered) and treatment in private hospitals (where a fixed monetary amount must be covered).

From a more general economic policy perspective, the Regulations do allow for insurers to manage claims and claims behaviour in the marketplace and facilitate competition between suppliers.

Considerations

As regards public hospitals, the main thrust of submissions from insurers was to treat all acute hospitals (public and private) the same. This view was also reflected in a number of other submissions, including the IMO. The balance of submissions was that provisions in the Regulations that facilitated competition between suppliers should be enhanced, although the import of a minority of submissions would have the effect of constraining insurers in their choice of suppliers.

The issue arises in respect of Minimum Benefit policy whether, in this context, the requirement on insurers should be to provide cover for services within a geographical region, regardless of whether those services are provided in a public or a private hospital.

If there were to be no distinction in the Regulations between public and private hospitals, then insurers could have freedom in respect of cover for both public and private hospitals. Otherwise, it would greatly restrict the ability of insurers to constrain price increases and the growth in the volume of claims. Even if price regulation for private hospitals was introduced (which would in itself be a major regulatory undertaking with unpredictable economic consequences), it is likely that the total value of claims would rise significantly more rapidly as a result of obligatory cover. However, the Authority's view is that it is not feasible to allow an insurer discretion concerning insurance cover of public hospitals for the reasons discussed below. Therefore, the Authority considers that a distinction should remain in the Minimum Benefit Regulations between public and private hospitals.

Public hospitals

Many submissions, including those from the insurers, recommended that public hospitals and private hospitals be treated the same in the proposed new Regulations. Two issues need to be considered. Firstly, the vast bulk of emergency patients are admitted and treated in public hospitals, many of whom elect to be classified as private patients on admission to hospital. Secondly, the availability of hospital treatment for all medical conditions and diseases is substantially different inside and outside the Dublin area.

The Authority considers that emergency patients admitted to hospital should continue to be able to elect to be classified as private patients on admission. It is noted also that, when a patient is transported to hospital by the public ambulance service, the patient will be transported to a publicly funded hospital and will not have a choice in relation to which publicly funded hospital they are transported to.

Outside the Dublin area, the effective choice of hospital is much more limited within a reasonable distance of an individual's home. Furthermore, the on-going reconfiguration of public hospital services within many regions is reducing, or indeed eliminating, the effective choice of hospital within most regions for many medical

conditions and diseases and greatly reducing any effective choice for emergency patients.

Inside the Dublin area, there is an effective choice of hospital for almost all medical conditions and diseases. Furthermore, there is an effective choice of emergency departments, provided the patient is transported privately rather than by the public ambulance service. However, even within Dublin, patients travelling to hospital by public ambulance cannot choose the hospital and there is an "on-call" system for emergency departments. Also, there is limited availability for treatments of many medical conditions and some treatments are only available in a limited number of hospitals.

An alternative to requiring that cover be provided in all publicly funded hospitals is to require that cover be provided for all services within geographic regions. However, the Authority considers that such an approach would not necessarily ensure that those admitted as emergency patients would be in a position to opt to be classified as private patients and it could lead to a reduction in the level of coverage and a consequent reduction in the extent to which private health services are available within a reasonable period of time within a reasonable distance of a patient's home.

This recommendation is made on the assumption that the Minister will continue to set the charges for private patients in all public hospitals and that individual hospitals would not be free to set their own charges. If individual hospitals were free to set their private charges, some form of price regulation for public hospitals would probably be required, especially in view of the dominant position in many regions of one large regional or university hospital.

Private hospitals

To promote economic efficiency, it is important to retain a provision similar to the current Article 9 that allows an insurer not to cover some private hospitals. Article 9 states the following:

> "Where
>
> (a) the provision of specified prescribed health services by a health service provider is not covered under the terms of a contract; and
>
> (b) the specified prescribed health services concerned could have been provided by a health service provider who is specified in that contract,
>
> then notwithstanding articles 5 and 6, a registered undertaking shall not be required to make a prescribed minimum payment in respect of those prescribed health services."

The charges in the current Schedule A for private hospitals are considerably out of date and need to be updated. A review of these charges would have regard to the current schedules of benefits used by insurers and to a direct assessment of current private hospital charges.

In circumstances where private co-located hospitals that are required to accept emergency patients and are the main providers of private hospital services in some regions are opened, similar issues may arise in respect of these hospitals as arise in respect of public hospitals. Consequently, the Authority considers that, in these circumstances, Minimum Benefit Regulations may also need to require that cover be provided in these hospitals, but this should only be done if they are subject to price regulation as the public hospitals are.

Recommendation

Minimum Benefit Regulations should maintain the distinction between public and private hospitals. The Regulations should require that products providing cover for in-patient hospital care cover all public hospitals for the full hospital charge for treatment in a semi - private bed, including the daily statutory charge. Article 9, which allows insurers selectivity as to which private hospitals they cover, should remain.

Section 6 - Updating and Simplifying the Regulations

Need for Review

The Regulations were drafted in 1996 and require updating in terms of the monetary amounts and some medical and surgical practices specified therein. Since 1996, the consumer price index has increased by 50% and the health sub-index of the consumer price index has doubled. The key components of health cost inflation for hospital services (doctors' fees and hospital charges) have more than doubled.

The Government has applied increases in private bed charges in public hospitals in recent years in pursuit of its policy of economic pricing of private beds in public hospitals. Among other effects, this has resulted in a disparity between the minimum benefit levels for private stays in public hospitals and private hospitals. From 1st January 2011, private bed charges will be €889 for semi-private accommodation in regional and major voluntary hospitals, which is the required level of cover for public hospitals in the current Minimum Benefit Regulations. In addition, the public hospital daily charge of €75 must be paid for the first ten days in any one year, except for those with medical cards. In contrast, the minimum payment in respect of a daily bed charge in a private hospital is €171.41, when the list of special procedures in Schedule B of the Regulations does not apply.

In addition, there have been significant changes in some medical and surgical practices in the last fourteen years. New drugs have been introduced and some medical related technologies have either been introduced or significantly enhanced. There has been a substantial increase in the proportion of elective procedures done on a day-patient basis rather than an in-patient basis.

Consequently, the Minimum Benefit Regulations need to be reviewed in order to reflect changes in medical practice (including changes in the setting in which health services are delivered) as well as changes to the costs of health services.

The current Regulations run to over 100 pages and include long tables of monetary amounts for specific procedures. Rather than merely updating the schedules, it has been suggested that it would be beneficial to simplify the requirements by avoiding a detailed list of procedures.

Considerations

Although some submissions to the consultation process suggested that the detailed schedules in the Minimum Benefit Regulations be replaced by a "principles based approach" or non-monetary (such as percentage) requirements, the balance of the submissions argued that the detailed format of Minimum Benefits Regulations should remain. Many submitters considered that an effective regular updating to allow for new medical developments and cost inflation is readily achievable.

The Authority considers that proposals for greatly simplified Minimum Benefit Regulations may either be difficult to enforce (such as principals based approaches) or may weaken the position of insurers in their negotiations with providers and consequently lead to an increase in premium inflation. For example, if an insurer is required to cover a percentage of the cost, the insurer must increase the amount payable to providers when the charges are increased.

While it is recognised that practical issues arise with regard to updating and maintaining detailed minimum benefit schedules, the Authority agrees with the submissions that argue that an effective regular updating should be achievable that would allow for new medical developments and cost inflation.

In updating the schedules, regard should be had to expert medical advice, insurers' current levels of allowable charges and the lower end of the range of costs for healthcare services currently applying in the market. In general, the Authority considers that minimum benefit levels should be set somewhat below the current market levels so as to provide for the possibility of negotiated gains by insurers, especially in the context of current market conditions.

In order to ensure that the Regulations remain up to date, there should be statutory provision for a periodic review of the schedules.

Recommendation

Maintain schedules in the Regulations detailing the minimum benefit levels for specific healthcare services, but update the schedules, having regard to expert medical advice, insurers' current levels of allowable charges and the lower end of the range of costs for healthcare services currently applying in the market. In general, minimum benefit levels should be set somewhat below the current market levels.

There should be provision for a periodic review of the schedules.

In addition to updating the schedules, the submissions to the consultation process suggested a number of areas in which minimum benefit levels could be reduced. In this regard, the Authority considers that the updated schedule should include the following provisions in respect of long term hospital stays:

Recommendation

In respect of long term hospital stays, Minimum Benefit Regulations should provide for the following:

- A lower minimum payment for hospital stays longer than 100 days.
- A sliding rate the minimum benefit for hospital consultant's daily charge for longer inpatient stays.

Section 7 - Primary Care and Chronic Disease Management

Need for Review

Primary care

When asking the Authority to undertake a consultation in relation to Minimum Benefit Regulations the Minister informed the Authority that "The Government has decided that the Minimum Benefit Regulations need to be amended to reflect better how healthcare is delivered in a modern context including the current plans for the public healthcare system. In particular, the Government is anxious that the emphasis on acute hospital care should be removed, and that minimum benefits should emphasise the trend towards primary care, care in the community and measures to promote health, including chronic disease management."

It is acknowledged that aspects of the delivery of public health services are currently under consideration including with respect to the delivery of primary care services. For example, the Report of the Expert Group on Resource Allocation and Financing in the Health Sector[3] made a number of recommendations relating to the provision of healthcare services. While some matters have yet to be determined, the trend toward greater healthcare delivery in primary care settings and the increasing emphasis on chronic disease management are already clear.

In addition to new developments in medical and surgical practices, there have been significant changes in healthcare public policy since the current regulations came into force in 1996, most notably the primary care strategy published in 2001, which stated, *inter alia*, "The Health Strategy 2001 sets out a new direction for primary care as the central focus of the delivery of health and personal social services in Ireland. …Primary care is the appropriate setting to meet 90-95 per cent of all health and personal social service needs. The services and resources available within the primary care setting have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier hospital discharge. Primary care needs to become the central focus of the health system."

A central feature of current healthcare policy is that primary and community care and medical assessment units will lead to a reduction in emphasis on acute hospital care. In addition, it is intended that some conditions that are currently treated in in-patient and day-patient hospital settings would be treated at primary care level. The primary care strategy applies to the entire population, not just the proportion of the population that have medical cards. In addition to the general primary care strategy, there are new policy developments for particular aspects of healthcare, such as chronic disease

[3] Report of the Expert Group on Resource Allocation and Financing in the Health Sector, 2010

http://www.dohc.ie/publications/resource_allocation_financing_health_sector.html

management and care in the community, which would also be expected to result in the avoidance of some hospital admissions.

If increasing the emphasis on primary care results in illnesses being treated in primary care settings that used to be treated in acute hospitals, then the result would be that the 1996 Minimum Benefit Regulations would not require that these treatments be covered to the same extent. This is because the minimum benefit payments for out-patient services are lower than for in-patient services and the Regulations do not apply in respect of treatments provided by many primary care providers. For example, in certain circumstances, drugs and other therapies could possibly be administered in a primary care setting even though the cost of the drugs could exceed many thousands of Euro in one year. Such drug costs come within the current Minimum Benefit Regulations when administered in an in-patient or day-patient setting but mostly not if administered in a primary care setting (although the patient may be able to recoup some or all of the costs from one of the State schemes for the reimbursement of drug costs). In this context, it can be argued that the Minimum Benefit Regulations need to be broadened in order to protect consumers against underinsuring for primary care services.

Chronic Disease Management

Improving chronic disease management is an important aspect of current healthcare policy and the primary care strategy. Substantial potential outcomes are desired for better health, patient satisfaction and economic efficiency. Achieving the desired outcomes is likely to require significant adjustments in the manner in which different healthcare services are delivered and coordinated with each other. Such adjustments may also have significant implications for how those healthcare services are financed.

To the extent that one focus of chronic disease management is to minimise emergency admissions and acute hospital stays, this may include frequent health monitoring and treatment in primary care. Frequent visits to general medical practitioners and other primary care episodes can be expensive for people without medical cards. While some existing health insurance policies provide significant out-patient and primary care cover, claims are often limited by one or other contract term, e.g. by the number of visits allowable for a claim, the amount payable per visit, an overall primary care claim pay-out, etc. These limiting terms for primary care claims contrast with the relatively more open-ended public health system cover and private insurance cover for acute hospital in-patient stays. Such a contrast necessarily gives rise to a financial incentive for patients (especially those without medical cards) away from primary care and towards acute hospital stays. This emphasis on hospital care over primary care and chronic disease management, contrasts with overall Government policy on the provision of healthcare services.

Considerations

A key feature of many submissions to the consultation process was the impact that a requirement to cover primary care could have on the affordability of health insurance. One example provided was that if, on average, every insured person made a claim for two GP consultations per year, the price of the lower value plans would increase by between 7% and 10%.

The insurers were against a general minimum benefit for primary care. However, more than one of the submissions was willing to countenance some inclusion of some aspects of primary care within minimum benefits, e.g. some aspects of chronic disease management or diagnostic procedures. Some other submissions proposed that all medically necessary primary care services be covered by Minimum Benefits. Such suggestions tended to be linked to an assumption that there would be some related reduction in hospital in-patient care.

In considering the issue of Minimum Benefit for primary care, the Authority had regard to a Report on the matter, which it commissioned, by Dr Peter West, health economist ("the Peter West Report") [4]. This Report is published on the Authority's website at www.hia.ie.

The Authority has identified three possible options for extending minimum benefits to primary care cover;

(a) General cover of primary care
(b) General cover of primary care with a substantial annual excess for claims for primary care
(c) Mandatory cover restricted to those with certain chronic diseases/conditions

The Authority does not consider that option (a) should be implemented at this point in time, especially because of the implications for a substantial increase in total claims and consequently for potential premium increases and a negative demand effect for voluntary health insurance. In turn, this would have price effects in the health insurance market and would therefore lead to some higher level of policy cancellations and lower take-up by new entrants to the workforce. However, it could be expected that relatively few older subscribers would cancel their policies because a relatively greater number of older subscribers would have a high expectation of a hospital care episode in the short to medium term. A requirement for general coverage for primary care may also lead to a substantial increase in the price of children's policies, which would lead to a larger payment burden on families.

Currently, many health insurance policies offer cover for partial reimbursement of GP and other practitioner visits up to a limit of visits per annum, which is typically around 20 for a GP and half that or less for other practitioners (e.g. physiotherapy). However, it can be argued that primary care consultations are generally relatively low cost and high frequency events and that these characteristics make insurance cover for

[4] Report by Peter West, Health Economist for the Health Insurance Authority on "Minimum Benefit Regulations and Primary Care" (available on www.hia.ie or from Health Insurance Authority, Canal Rd, Dublin 6)

these events less valuable to consumers[5] in general. While universal or national health insurance systems often include cover for all aspects of health service, it is generally a feature of voluntary health insurance systems that cover is, in the main, related to high cost, low frequency unpredictable events. This argument also applies to option (b), which would be intended to minimise the effect on total claims and consequently premiums. In addition, option (b) is unlikely to change behaviour and therefore affect the incentive for insured people to use hospital care rather than primary care. In contrast, insurance against the potentially high costs of primary care chronic disease management in Ireland is of potential value to consumers[6]. It would also be a significant step in linking in the health insurance system with implementation strategies to achieve the healthcare policy objective of integrated models of healthcare. An important aspect of this objective is to move service delivery for chronic diseases into non-hospital settings

Most of the 67% of the population who do not have medical cards have health insurance. If all health insurance policies included significant cover for chronic disease management in primary care, this would have a substantial effect in eliminating the financial incentives that currently exist for private patients with chronic diseases towards hospital and consultant care and away from primary care. Consequently, such a development would contribute towards the national healthcare objective of moving service delivery for chronic diseases into non-hospital settings.

On-going implementation of the primary care strategy among the 50% of the population with health insurance should result in hospital related claims being lower than they would otherwise be, provided that the insurers' claims management is effective in facilitating the appropriate shift from acute hospital to primary care.

The issue arises as to whether non-hospital prescription costs for chronic disease sufferers should also be covered in Minimum Regulations. The Peter West report did not recommend this because of the implications for insurance claims and premiums and because private insurance in other countries with a public sector health service does not typically cover this cost. Three public sector schemes cover a substantial proportion of primary care prescription costs for chronic diseases[7]. However, there are some gaps in those schemes and the threshold in the Drug Payment Scheme is €120 per month. Given that in-hospital prescriptions are fully covered by insurance, a financial incentive exists for chronic disease sufferers to be treated in hospital rather than outside hospital. Therefore, it might be sensible to include a provision that mandatory insurance cover for prescription costs incurred for chronic disease sufferers in excess of reimbursement by the State that is more than (say) €350 per annum should also be covered under Minimum Benefit Regulations.

On consultations, the Authority's recommendation is that a list of chronic diseases be established, which would be subject to review at regular intervals. Any individual with one of the listed chronic diseases must be reimbursed up to a maximum amount

[5] Ibid
[6] Ibid
[7] Drugs Payment Scheme (DPS), Long Term Illness Scheme (LTI), Hi Tech Drugs (HTD)

(in a Schedule) for up to (a certain number of) consultations each year with various healthcare practitioners (listed in a Schedule).

Recommendation

Minimum Benefit Regulations should include a list of chronic diseases, each with an associated prescribed level of minimum primary care benefit. Those diagnosed with the chronic disease would be entitled to receive the prescribed benefit. The benefit would include cover for a set number of consultations with suitably qualified healthcare professionals (up to a fixed monetary cost per consultation) as well as cover for part of any cost of prescription medicine not recoverable from a state Scheme.

The list of chronic diseases and the associated prescribed benefit levels is to be determined having regard to expert medical advice.

Section 8 - Supporting Community Rating

Need for Review

In the context of increased market focus on risk segmentation, the question arises as to whether the Regulations need to be amended in order to provide further support for the community rating system.

In current market circumstances, insurers have a large incentive to segment their membership so that older and less healthy people are sold different products to younger and healthier people. Such a strategy enables insurers to charge higher premiums for the products purchased by older and less healthy people. One way that insurers can segment their risk profiles is to provide reduced benefits for treatments used by older and less healthy people on some of their products. There have been some recent product developments along these lines and the Authority considers that these developments will evolve and intensify unless there are changes made to the legislation governing health insurance.

Considerations

The Authority considers that the issue of risk segmentation is best addressed through risk equalisation, which reduces the incentive for insurers to engage in segmentation. However, risk equalisation will not be able to eliminate this incentive and so it is necessary to ensure that the Minimum Benefit Regulations also provide sufficient support to community rating.

The Authority considered whether the Minimum Benefit Regulations should explicitly prohibit insurers from offering different levels of cover for different treatments within the same hospital. Such a provision would provide further support to community rating but would also limit insurers' ability to negotiate with providers, to use some hospitals only for certain high value specialist operations or procedures or to use different preferred providers for different services. On balance, the Authority is of the view that, while such a provision may be necessary in the future, it would be better not to introduce it unless there was a further intensification of the trend of insurers using product development to segment the market.

Recommendation

Monitor the impact of changes to the risk equalisation system in order to assess how successful the amended system is in addressing risk segmentation strategies. If there continues to be an increase in the extent to which product design is used to segment the market then consider amending the Minimum Benefit Regulations to prohibit insurers from offering different levels of cover for different treatments within the same hospital (subject to prescribed exceptions, such as where a hospital provides a national specialty).

Section 9 - Other issues

Important aspects of in-patient healthcare are treated separately in the current Minimum Benefit Regulations. It needs to be considered whether these aspects ought to be treated differently in any new or revised Regulations, and if so, how. These aspects, which have also been considered by the Authority in its review, are:

- maternity care
- psychiatric illness
- step-down nursing home care

In addition the Consultation Paper requested views in relation to whether the Minimum Benefit Regulations should provide explicitly for maximum excesses allowed in health insurance policies.

Maternity Care

Most references to the topic in the submissions suggested that there should be no change. The Authority considers that the prescribed minimum benefit levels for maternity care should be updated along with the other minimum benefit levels in the schedules.

Psychiatric Conditions

The Minimum Benefit Regulations provide that the minimum benefit requirements apply only for the first 180 days hospital treatment in any calendar year for most medical conditions. An exception to this is the treatment of psychiatric conditions. In respect of psychiatric conditions, minimum benefit requirements apply only for the first 100 days. The Authority considers that the number of days for which minimum benefit rates apply should not vary with respect to the medical condition or the treatment unless there are strong objective reasons for such differentiation.

Where submissions referred to the topic of minimum benefit requirements for psychiatric conditions, most references stated that the Minimum Benefits should be the same as for other hospital care. The Authority agrees with this view.

Recommendation

There should be no distinction in the Regulations between psychiatric and other conditions as regards the number of days for which treatment must be covered.

Step-down nursing home care

The availability of step-down care is important in reducing the length of stay in acute hospitals for private patients. Typically now, patients have to pay a substantial co-payment to the nursing home because the payment level offered in most insurance policies is considerably less than the market rate. The Authority considers that the obligation for cover should be fourteen days but that the minimum payment level needs to be reviewed. This level would be reviewed as part of the process updating the Regulations.

Excesses

The 1996 Regulations place no explicit limit on the amount of excess that may be included in a health insurance policy. However, excesses are in effect limited by the requirement to provide full cover in respect of public hospitals and by the minimum benefit levels for private hospitals and hospital consultant services. The Authority considers that, following an update of the Schedules, these provisions will be sufficient and that no further provision is required in respect of excesses.