THE HEALTH INSURANCE AUTHORITY

Submission to the Department of Health and Children

Minimum Benefits

September 2005

1 Introduction

The purpose of this submission is to set out The Health Insurance Authority's ("the Authority") views on issues relating to minimum benefits, including changes to the Minimum Benefit Regulations (S.I. No. 83 of 1996) proposed by the Government in the White Paper on Private Health Insurance, 1999 (the White Paper).

The current Minimum Benefit Regulations incorporate detailed prescriptive schedules of treatments and minimum amounts of cover that insurers are required to offer for each of these treatments. The minimum amounts specified for treatments in the current regulations are in monetary terms. Amounts for hospital accommodation are determined by reference to monetary amounts or proportions of hospital charges.

In the White Paper, the Government set out its proposals to revise the minimum benefits system. In particular, proposals were presented to simplify the system from its current structure and also to allow more flexibility to adapt to market developments. In some instances, it was envisaged that the Authority would have a role in determining minimum benefit levels. Further details of these proposals can be found in Chapter 5 of the White Paper.

This paper begins by briefly describing the consultation process engaged in by the Authority and then describes the Authority's views with regard to the key issues raised during its deliberations on the matter and other issues that arose during the consultation process.

2 Consultation Process

The Authority issued a consultation paper on 31 October 2003 regarding minimum benefits. This paper was distributed to a large number of stakeholders including consumer groups, insurance undertakings, professional bodies, industry bodies, legislators and healthcare providers. The consultation paper requested comments on issues relating to minimum benefits.

The following provided submissions in response to the Authority's consultation paper:

BUPA Ireland
Centura Health Administration Limited (now VIVAS Insurance Ltd)
The Competition Authority
The Consumer's Association of Ireland
Health Boards and ERHA Chief Executive Officers Group
Independent Hospital Association of Ireland
Society of Actuaries in Ireland
Vhi Healthcare

In the interests of transparency the Authority has decided to publish the responses received in relation to the consultation paper. Responses are published on the Authority's website at www.hia.ie.

The Authority is grateful for the submissions received and wishes to acknowledge the assistance that these contributions provided to the Authority during the course of its deliberations.

3 Views of The Health Insurance Authority on Key Issues

3.1 Principle

The Authority is mindful that a balance needs to be struck between providing a degree of certainty and protection to consumers, and support to the system of community rating that operates in the Irish market, and allowing insurers the commercial freedom to engage in innovation in product design, which has the potential to benefit consumers in terms of greater choice. The Authority supports the principle of specifying minimum benefits that health insurance contracts should cover but agrees that a degree of simplification would be beneficial.

3.2 Review of Minimum Benefits

The Authority is of the view – as are a number of those who made submissions – that the current Minimum Benefit Regulations are now significantly out of date, as the monetary amounts specified were not inflation linked and are therefore still in 1996 prices. Between March 1996 (when the regulations came into effect) and August 2005, inflation in the Health category of the consumer price index amounted to approximately 80%, while the CPI price index for health insurance has approximately doubled over the same period. However, it should be noted that most products available in the Irish market provide benefits significantly in excess of those specified by the regulations.

Inflation linking of minimum benefit levels was suggested by some of those who made submissions, while others cautioned that this could, in itself, be inflationary. There was also a divergence of views on what measure of inflation to use, should inflation linking be adopted. The Authority would suggest that minimum benefit levels should be reviewed on a regular basis, rather than linked to a set measure of inflation. However, the Authority is conscious that such reviews, though worthwhile, would also be resource-intensive. The view was also expressed that setting minimum benefit levels in monetary terms could create a price floor and thereby be anti-competitive.

The Authority would therefore suggest that, where possible, minimum cover for treatments should refer to the full cost of the procedure or a set proportion of the cost. This would provide consumers with the reassurance that, as the cost of the procedure rises, so too does the level of cover (which is not guaranteed under the current system), while also providing an incentive for insurers to control the costs of these procedures through negotiations with healthcare providers. This would allow insurers to compete on the basis of their cost agreements with providers and has the potential to be anti-inflationary.

The Authority notes, however, that such a method also has the potential to lead to higher prices. Whether the outcome is pro or anti-inflationary would depend on the relative degree of bargaining power of insurers and providers. In this regard, the Authority is mindful of the Competition Authority's current investigation into the agreements between insurers and hospital consultants. If an individual provider charges a considerably higher fee for providing a service than other providers of the same service, then requiring insurers to cover the same proportion of the cost of the treatment by that provider as by other providers could lead to cost pressures on insurers. It should be noted that insurers have the option of not entering into an agreement with such a provider. However, widespread occurrence of this practice could be detrimental to the private health insurance market in general. The Authority could monitor such activity and, if this system proves inflationary, could suggest an alternative system of reimbursement. In this regard, consideration could be given to having an upper limit, set as a proportion of the average cost of a given treatment, above which insurers would not be obliged to meet the prescribed proportion of the cost.

Since the current regulations came into force in 1996, there have been significant advances in medical technology and best practice. This trend is likely to continue into the future, and the Authority is of the view that this should be accommodated in any new minimum benefit regime. The Authority would therefore suggest that the type of cover specified by minimum benefit regulations, with regard to procedures, etc., should also be reviewed on a regular

basis. The Authority would envisage having a role to play in such a review, which would also require the involvement of medical experts.

3.3 Scope of Minimum Benefit Regulations

The current Minimum Benefit Regulations cover payments in respect of hospital charges (in-patient and day-patient services), hospital charges relating to special procedures, consultants' fees (in-patient and day-patient services) and hospital charges and consultants' fees (out-patient services).

The Authority does not consider it necessary to extend the scope of such regulations at this juncture, as the primary purpose of private health insurance is to provide cover for hospital treatment. Research commissioned by the Authority into consumer attitudes[1] confirmed that this was the element of cover considered most important by over three quarters of consumers. However, the Authority will continue to monitor this situation with regard to the scope of the regulations, particularly in view of the rapid changes in product design seen in recent years.

3.4 Role of The Health Insurance Authority

Under the system of minimum benefits outlined above, with reference to the degree of cover for benefits rather than monetary amounts, the role of the Authority in setting and reviewing appropriate reimbursement rates would be reduced, compared with a more prescriptive approach. The Authority would still have a role to play in reviewing the minimum benefit system (see also section 3.2) and any reimbursement levels therein, particularly any levels set with reference to monetary values, and in monitoring the effectiveness of the reimbursement method in subduing inflationary pressures. The Authority would also continue to monitor the application of any revised minimum benefit regulations. It should be noted that increased monitoring of the minimum benefit system would have resource implications for the Authority, and this may require attention.

[1] *The Private Health Insurance Market in Ireland: A Market Review, September 2005*, prepared by Insight Statistical Consulting. Available on the Authority's website at www.hia.ie.

4 Other Issues Raised

A number of other issues were raised in submissions to the Authority in connection with this consultation process. These are detailed below.

4.1 Minimum Benefits and Community Rating

An appropriate level of minimum benefits is required in order to ensure the stability of the community rating system that operates in the Irish private health insurance market. Without it, product design could lead to an effective stratification of the insured community, with those who do not require significant coverage opting for a low-cost type of product, with low or illness-specific cover, leaving those most in need of treatment facing higher premiums for a more comprehensive type of product.

One suggestion that was made during the consultation process was that there should be a single community rated plan, covering minimum benefits, with all other products in the market being risk rated. All insurers in the market would be required to offer this plan, and it would be the lowest priced plan that an insurer could offer. The Authority sees some merit in the idea of having a maximum level of benefits to be community rated, but would be concerned that a switch to such a system would have equity implications for a large number of existing private health insurance consumers, who currently subscribe to plans offering cover considerably in excess of minimum benefit levels.

4.2 New Products

There were suggestions that plans covering a limited number of conditions (e.g. heart and cancer conditions) should be allowed, without having to also cover the minimum levels of benefits for all other listed conditions. The Authority notes that such plans are available in other private health insurance markets, such as the UK. Concern was also expressed that restrictions on the range of products that insurers may offer could hinder competition, to the detriment of consumers, by reducing the choice of insurance products available.

The availability of such plans would increase consumer choice, but the Authority would be concerned that, given the modest level of consumer understanding in relation to existing products (as evidenced in the consumer research mentioned above) the potential would exist for some consumers to under-insure by purchasing these products. Therefore, if such products were to be permitted, there would need to be clear differentiation between them and products that provide cover for a more extensive list of procedures. Furthermore, the level of cover for the limited number of procedures would need to be sufficient to justify the price of the products. If these conditions were met then the Authority would not object to such a change in the market, provided that such limited plans would be subject to prior regulatory approval by the Authority. If it appeared to the Authority that a limited cover product could undermine community rating, then it would not receive such approval. The legal implications of such prior approval requirements would need to be examined.

It was also suggested that excesses and co-payments should be permitted. The Authority notes that a number of products currently available in the market are subject to in-patient excesses. The Authority does not object to the principle of products involving excesses. However, as with products relating to limited conditions, it is concerned that consumers should be able to make fully informed choices and should therefore be fully aware of any limitations, such as excesses. The Authority also believes that any excess should be in proportion to the cost of the product, and would therefore suggest a maximum of 25% of the annual premium. The Authority would also prefer to see the use of annual excesses, rather than per-episode ones, as the latter effectively mean that insured persons who have more in-patient episodes pay more than those who have less or none, which is contrary to the spirit of community rating.

4.3 Consumer Understanding

Differing views were put forward about the level of consumer understanding of health insurance products. The evidence available to the Authority is that consumers do not fully understand their health insurance cover, and in this regard the Authority has taken steps to help increase the level of awareness among consumers. Such steps have included the production of a comparison table, comparing the main elements of the various health insurance plans available in the market, and consumer information leaflets, which have been nationally advertised. These documents are available on the Authority's website at www.hia.ie. Against this background, the Authority believes that minimum benefit requirements ensure a degree of protection for health insurance consumers, which is a desirable goal. The Authority would welcome the opportunity to inform consumers of any changes to the Minimum Benefit Regulations and how these will affect them.

4.4 Competition and Innovation

Arguments were made that restrictions imposed by Minimum Benefit Regulations could be detrimental to competition, that the current structure of minimum benefits stifles innovation and that arrangements should be loosened. The Authority is mindful of the balance that needs to be struck between consumer protection and the support of community rating on one hand, and the facilitation of competition and innovation on the other. In this regard, the Authority believes that the suggested alteration to the format of Minimum Benefit Regulations (see section 3.2) and the permitting of new product designs (see section 4.2) will allow insurers the commercial freedom to compete and innovate, while maintaining the degree of consumer protection for which the original regulations were designed.

5 Summary of Recommendations

In summary, the Authority's recommendations in relation to the proposed update of the Minimum Benefit Regulations are as follows:

- The system of minimum benefits should remain in place but be simplified.
- Where possible, benefits should be specified in non-monetary terms, such as a proportion of the cost of treatment. This would allow insurers to compete on the basis of cost agreements. If this system is circumvented by providers in a way that makes it inflationary, then the Authority would suggest an alternative, possibly in the form of a limit to the cost of the treatment, set with regard to the average cost of that treatment, above which insurers would no longer be obliged to meet the prescribed proportion of the treatment cost.
- The benefits contained in the minimum benefits schedule should be reviewed on a regular basis, to ensure that they remain up-to-date, given advances in treatment.
- If any benefits are specified in monetary terms, these should also be reviewed on a regular basis.
- The minimum benefit regime should not be extended to products covering relevant health services, although the Authority will keep this policy under review.
- The Authority would have a role in the review process and in monitoring any new system of minimum benefits.
- Although the Authority can see some merit in the idea of a single basic product, offered by all insurers, covering minimum benefits and being community rated, with plans offering cover above this level being risk rated, the Authority would have concerns about the equity implications of switching to such a system.
- Products covering limited procedures, such as heart and cancer cover, may be permitted, subject to prior regulatory approval by the Authority.
- Excesses should be permitted, but the Authority would suggest a maximum excess of 25% of the annual premium for the policy. The Authority would prefer to see annual excesses, rather than per-episode excesses.
- The Authority will continue to inform consumers of matters that affect them, including any changes that occur to the minimum benefits regime.