Submission to the public consultation on proposed changes to the risk-equalisation scheme in Ireland

Dr Conor Keegan,

Research Officer,

Economic and Social Research Institute,

Dublin 2

This document provides responses to the consultation document on proposed changes to the Irish risk-equalisation (RE) scheme. For clarity, I have structured my comments in line with the main questions raised in the consultation document. The views expressed below are solely my own and not that of the ESRI.

(1) Given that Ireland has a voluntary community rated market for health insurance, do you agree with the principle and overall substance of the Risk Equalisation Scheme?

Community-rating, which limits the extent insurers can vary premiums based on risk profiles, is a key feature on many health insurance markets, including Ireland. As noted in the consultation document, while promoting solidarity, community-rating creates a separation between the premium consumers pay and their underlying risk profiles and this can lead to insurer incentives to risk select.

Open enrolment and lifetime cover regulations tend to prevent direct risk selection – where insurers have the capability to explicitly influence who signs a contract. In practice insurers are faced with incentives that promote indirect risk selection - for example through plan design, differential service quality based on risk, adverting and marketing strategies. Risk selection can have a number of negative consequences, potentially resulting in market segmentation, poor service quality to high-risks, and a welfare loss as resources are focussed on attracting low-risks rather than price and quality competition. In that context, it is well acknowledged that the best strategy for reducing incentives for risk selection is robust risk-adjustment. This involves providing risk-adjusted premium subsidies to insurers based on insurees' risk profiles, generally administered through a RE scheme.

Therefore, a well-designed RE scheme is a key requirement of a competitive, community-rated, health insurance market such as Ireland's. Indeed the lack of RE in the early years of market liberalisation contributed to risk-based segmentation between insurers and undermined the principles of community-rating. While a RE scheme has been in place since 2013 the current set of risk-adjusters; age, gender, level of cover, plus a utilisation credit are unlikely to adequately compensate insurers for differences in risk and incentives for selection most likely remain (Keegan, Teljeur et al. 2017). This is particularly the case for very high-risk individuals where current RE credits will not fully compensate costs.

In this regard, refining the current RE scheme through the introduction of a high-cost claims pool (HCCP) is welcomed. A HCCP is a form of cost, rather than risk, equalisation as payments to insurers are calculated retrospectively based on observed expenditures. Retrospective cost-based compensation should reduce incentives on the part of insurers to risk select against high-cost consumers.

A well-known drawback, however, of retrospective claims compensation is that it reduces incentives for insurers to act efficiently as realised costs, rather than risk, are compensated. In that regard, an important feature of the HCCP is that only a portion of costs above €50,000 are reimbursed. This has been initially set at 40% however this percentage will need to be kept under review in light of insurers' behavioural response to the HCCP and in line with the weight placed by the regulator on reducing selection effects versus efficiency.

(2) Would the changes proposed affect your involvement in the private health insurance market?

-

(3) Are there risks or vulnerabilities that do not feature and should be included, and why?

The informational requirements on the part of the insurers under the current RE scheme are reasonably straightforward. Will this change considerably under the proposed new HCCP? For instance, will insurers be required to return individual-level information on high-cost claimants and are there data protection issues to consider? Relatedly has the regulator considered the resource implications of any additional data collection and processing burden on its operations?

A vulnerability of the proposed HCCP is that it does not distinguish between unpredictable high-costs claims (e.g. treatment following a serious motor accident) and more predictable high-costs claims (e.g. for those with multiple chronic

conditions). As it relates to risk selection, compensation should only be applied to the latter. In this regard, the Dutch risk-equalisation includes a set of risk-adjusters known as multiple-year high cost (MYHC) groups based on the level of curative spending in the previous three years. The fundamental assumption being that individuals who record multiple-year high costs are likely to suffer from a chronic disease, which can be considered a legitimate basis for subsidisation. Consideration should be given to whether refined high-cost claims reimbursement along these lines could be introduced in the Irish RE scheme.

Another potential issue relates to the extent that RE, and refinements under the HCCP, may act as a barrier to market entry. This is worth consideration given the concentrated structure of the market at present. Competition consists of three open market insurers with one insurer continuing to dominate market share. Prospective market entrants, who tend to initially attract relatively low-risk consumers, may be discouraged from joining the market as upon entry they will be net contributors to the RE fund. This net contribution will increase under the HCCP. While the principle of RE is to balance risks, given the current market structure it may be worth considering this issue.

(4) Do you have additional suggestions for refinement of the Risk Equalisation Scheme in Ireland?

While a HCCP will help reduce selection against very high-cost claimants it does less to address wider unpriced risk in the market. Therefore, incentives for selection are likely to remain. Aside from risk-sharing mechanisms such as a HCCP, the other approach available to reducing risk selection effects in the market is through improving the set of risk-adjusters in the RE model[1]. As already noted, incentives for risk selection are likely to remain under Ireland's current risk-equalisation design. In that regard, advanced risk equalisation models such as those observed in the Netherlands and Germany are centred on the use of diagnoses as a means of risk-adjustment and a wide range of international and available national (Keegan, Teljeur et al. 2016, Keegan, Teljeur et al. 2017) evidence suggests the efficacy of RE can be substantially improved through the use of diagnosis-based risk-adjusters.

[1] Risk selection effects could also be reduced through allowing insurers to risk-rate premiums. Some elements of this takes place in the market already for example through offering premium discounts to children and young adults, through lifetime community rating loadings, and implicitly through market segmentation. However, risk-rating is not a policy to be pursued as it reduces solidarity across the market and can make the purchase of insurance unaffordable to high-risks. Moreover, such a policy does not align with current principles underlying the market.

Over the medium, it is important that the introduction of diagnosis-based risk adjustment to the Irish RE scheme takes place. These payments should be prospectively set to maintain insurer incentives for efficiently. The introduction of diagnosis-based adjustment will be challenging for a number of reasons and steps will need to be undertaken in advance to facilitate its introduction. For instance, it is unclear at present the extent to which insurers and private hospitals have the ability to accurately and consistently capture and code relevant diagnostic information of claimants. Moreover diagnosis-based payments would increase informational and data processing requirements on both insurers and the regulator. Ultimately it would be necessary that individual-level claims information form the basis for credit calculation and assessment.

References

Keegan, C., C. Teljeur, B. Turner and S. Thomas (2016). "Switching insurer in the Irish voluntary health insurance market: determinants, incentives, and risk equalization." Eur J Health Econ **17**(7): 823-831.

Keegan, C., C. Teljeur, B. Turner and S. Thomas (2017). "Addressing Market Segmentation and Incentives for Risk Selection: How Well Does Risk Equalisation in the Irish Private Health Insurance Market Work?" Economic and Social Review **48**(1): pp. 823-831.