Aviva Health Insurance Ireland (Aviva)

Submission to the Health Insurance Authority on Minimum Benefit Regulations in the Irish Private Health Insurance Market

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INTRODUCTION

Aviva Health Insurance Limited, hereinafter Aviva, welcomes the opportunity to participate with the Health Insurance Authority (hereinafter the HIA) in this consultation process. Aviva supports any measure that strengthens consumer protection measures within the market. However, Aviva would caution against introducing any measure which will artificially raise premium costs at a time when the health insurance market has started to contract. In addition, in order to ensure that insurers can maximise efficiencies both through their own operations and those of health care providers the interference with their commercial freedoms should be minimal once consumer protections are ensured.

Currently all person are entitled by legislation to free hospital treatment and fee consultant care, in a public hospital in a public ward. This "free" treatment is financed directly by the public in terms of direct taxation in respect of PAYE payments and from the health levy on earnings. Thus having agreed that a member of the public having paid their taxes (or been in receipt of social assistance), then the issue is what is to be legislated for as their basic minimum entitlement under their contract of insurance.

The concept of Minimum benefits is as Aviva understands designed to be a set of benefits that are guaranteed to all members (irrespective of age, sex, race or religious belief) which are designed to ensure that the holder of a health insurance plan, can have reasonable certainty that a certain level of medical care cover will be available to them to cover their reasonable and medically necessary and appropriate medical costs in their time of illness.

Traditionally the term "minimum benefits" has related to that level of care and cost incurred by a member when not in receipt of primary, continuing or long term care, but referred to inpatient (secondary and tertiary care) only. However such a limitation does exclude valuable services in both a preventative and maintenance / control of disease status which may or may not be carried out and supplied within what was traditionally called an inpatient environment.

The system in Ireland whilst not integrated between the independent (private) sector and the Public sector, does however share many commonalties and uses of facilities in terms of physical resources and medical manpower. Thus the concept of the definition of "which

services" to be included in minimum benefit legislation, requires the application and understanding of the integration of the two systems.

1. **What services should be included in minimum benefits regulations or alternatively how should benefits to be included in Minimum Benefits Regulations be determined?**

   While the minimum benefit regulations are lengthy their current structure is beneficial in that it provides transparency and certainty to all stakeholders on precisely what procedures are covered. Aviva would favour retaining (after updating) the current list structures. Aviva believe that the list of services that should be included should be those set out within the public hospital system but with certain exceptions (as at present) i.e. the national specialities in common areas e.g. transplants. The list could then be amended in line with changes within the public hospital system.

   Aviva would not support the proposal to assign a function to the HIA to determine either the services or the cost levels to be determined. Aviva would respectfully submit that the Health Service Executive and the Department of Health and Children are better placed in determining what should be provided under the public hospital system and there would be no rationale for duplicating this work. In addition to which there would be a real danger that two divergent set of services would be created and there does not appear to be any necessity to define a differing level of cover under private health insurance contracts to that provided under the public health system – why should private patients be entitled to more or less service coverage to that afforded to a public health patient?

   When assessing whether any new benefit should be provided for under minimum benefits the following must also be considered:

   - That all health care providers and medical professionals are appropriately regulated and are operating under the highest recognised clinical standards.
   - That the specified surgical and medical procedures be proven to be ethical, internationally recognised with proven outcomes based on international standard e.g. QALY (Quality adjusted Life in Years) score.

2. **At what levels should minimum payment levels be set, or alternatively, how should minimum payment levels be determined?**

Affordability is a key problem currently within the health insurance market. Consumers are currently both down-grading insurance coverage or stopping coverage entirely due to economic conditions. As such no additional cost pressures should be artificially added. In addition, the lower level plans and their pricing point for the more economically sensitive must be maintained.

There is a real danger that if new revised rates are set down within the legislation that this will cause an automatic inflationary effect on all plans. In particular, in instances were insurers are already fully covering a procedure at a given rate if the HIA were to now lay down a new rate that would automatically raise costs (at no added benefit to the consumer who would already have had coverage). As such Aviva would not recommend automatic increase across the rates set within the current regulations.

Aviva would suggest that rather than setting down base rates, which will by necessity firstly have an inflationary impact and secondly will at least require constant updating that a differing approach be adopted by the Authority. To this end Aviva would recommend that:

- The rate of coverage be the lowest rate at which a provider can give full coverage for one of the designated services, within either a private, or a public hospital/facility.
- This rate would need to be reasonable in light of the cost of the procedure, to ensure that insurers were not unilaterally manipulating the providers to set a very low base cost;
- Each insurer would keep records of what its minimum benefit for each service for audit purposes by the Health Insurance Authority.

As all insurers would be required to provide minimum benefits on all plan, and it is recommended that health care provider coverage be within a geographical area this would mean that all consumers would have sufficient protection regardless of whether they were

on a lower level plan within any given area. The aim of ensuring consumer protection without making minimum benefits inflationary would also be achieved.

In addition, the current consultation paper needs not only to take account of rates, but of modern service development, outcome analysis, government policy. An example of this would be the national breast care strategy which is driving breast cancer services to 8 national centres of excellence, but without any reference to private hospital care. Thus if a minimum benefit rate is set for breast surgery and in the absence of any legislation a hospital performs this surgery, then Aviva along with all other insurers may be forced to cover this surgery, whilst it is not in accordance with government policy or best international practice. Thus rates cannot be set in isolation of standards, availability, national directive, international and national standards and critically outcome analysis.

On more specific types of coverage, Aviva would state the following:

Primary care

- There should be a flat rate for a set number of GP visits up to a maximum for specified providers where insurers can negotiate the best possible rates in order to contain costs. There should be flexibility to allow for co-payments in order to ensure affordability of premia.
- The primary care benefits that should be included are prescribed health screens based on age / sex / family history cohort of members, to be performed on agreed intervals.
- That provision be made for an increase in the role of the General Practitioner in surgical care, in that such cost be become an integral part of any health policy. The criteria being as those applicable to any hospital (with a lower standard due to the lower intensity of work being undertaken).

Continuing/Long Term Nursing Home care

- This is not an area for the provision of health insurance cover, as it is not covered under current legislation. Thus there should be no obligation on insurers to provide cover for this care, other than that supplied by the insurer under their contract for insurance. In addition, the Government has already elaborated a national policy through the "Fair Deal" programme that sets out a regulatory framework for this type of care.

Chronic disease management

- The nature, cost and specification of such services would of itself require a complete paper. In broad terms however insurers in a the interest of cost management should contribute to the cost of their members for accredited, proven and valid programs supplied by recognised and approved provider to agree limits and with agreed excess for specific preventable and controllable illness/disease. In addition, insurers should have a mechanism to incentivise members to participate in such programmes and reward appropriate behaviours, similarly, if a member repeatedly ignore or breaches a programme then there should be no obligation for the insurer to continue to provide this benefit.
- The mandatory introduction of chronic disease management (at time where this is not currently present within the public system) on all plans would lead to an unnecessary cost within premiums – and a greater cost impact on the smaller insurers in the market. If alignment is to be attain within the public coverage and the private coverage then these should be introduce at a similar time – with a particular focus on the need to contain costs.

Taxation allowance

- To encourage person to fund their health care and to assist them with these costs, the continuation of relief on health care expenses at the standard rate is recommended. This is because not only does it encourage persons to look after their health and to reduce the cost, it also encourages and ensures that medical professionals are tax compliant.

- Again to allow for persons to continue to invest in their health and to lessen the burden on the public purse nearly 50% of the population have PHI, then the allowance of the cost of private health insurance against the persons taxation bill at standard rate is recommended. At a time of market contraction, the burden of which is then placed upon the public healthcare system, the need to for strong tax reliefs to maximise uptake and retention is crucial.

Out-Patient Benefits

Aviva would agree with the current structure vis-a-vis out patient benefits where specific diagnostic tests and investigations are covered at a basic amount (to cover both professional fee). Aviva would highlight that while the extent of minimum benefit payments in the current regulation is low, insurers have provided a much broader range of out-patient benefits to its members. As such competitive pressures and commercial freedom in relation to plan structures will continue to ensure that out-patient benefits are adequately covered.

Payments

That to assist payer and payee that the statute of limitation on bill submission be shortened in the case of medical care to 6 months. Other issues that should be considered when deciding on rates:

- Payment for quality or outcomes should be permitted, The need for outcomes is of concern particularly to members of the public (patients) and insurers (payers) to validate the efficacy of doctor's interventions, their success ratio and this will also allow informed patient choice.
- Coding – that an agreed international coding standard be adopted)e.g. ICD10-AM) to allow for comparability of cost and outcomes from both a national and international basis
- Medical Prescription fees – as a person is entitled to full reimbursement of cost above €120 per month under their Social welfare entitlements (see also LTI and DCSS schemes), then in respect of the liability of the insurers, again refer to the basis proposed in the Expert group as set out in schedule 4.1
- Appliances – this should be a matter for the individual insurer and person to decide

- Other Medical professionals – this ranges across the broad spectrum of care and including medical, complementary and alternative care providers. Again this should be a matter for the individual insurer and member to decide.
- It should be possible to allow the application of discounts for prompt claims payments by insurers.

As previously stated Aviva would support the view that an insurer must be bound to provide a choice and range of hospital services to a member to honour the cover purchased by the member within a distance of 100km (or such other distance as the HIA may deem appropriate) from their home, subject to availability of the service and it efficacy, safety and accreditation status of the facility.

3. **What measures are necessary to ensure that the list of services remains up to date with medical developments?**

If the level of minimum benefit is set against the provisions of services within the public hospital system then the updating of the list should occur annually having reviewed what new medical developments have been introduced within the public system. While the Minimum Benefit regulations have been in place since 1996 the level of coverage provided by insurers has constantly been changing and updating to keep abreast of medical developments. Insurers have an interest and trade upon bringing new benefits and medical developments within their plans; as such competitive pressures by themselves will also help ensure that the list of services remains up to date.

Prior to any new service being added to the list however, it is of paramount importance for patient safety that international guidelines are used to assess each new procedure e.g. NICE or the new US Body proposed namely the Institute of Technology and Outcomes Assessment. For surgical and medical interventions which would also adjudicate upon the QALY aspects. For drug therapies EMEA / IMB or US FDA approval would be a prerequisite, with price being applied as the IPU price net of any rebates / volume discounts. For services such as Ambulance care matters such as PHECC certification, CEN Certification would be requisite and for medical professional registration with appropriate recognised medical groups based on agreed registration, accreditation and CPD processed would be required

The question here relates to government policy, in that recent government policy in terms of for example medical labour rates have directly caused a surge in medical inflation and now a deflation in medical costs.

Medical costs would require a sophisticated review based on an annual review of input costs for specific procedures and it must also to allow for the use and change in use of medical services (drugs, consumable) and technology a (e.g. minimal invasive surgery) which has in many cases reduced the per unit cost including Length of stay (LOS) for many procedures on an annual basis.

4. **Should the manner in which minimum payment levels be simplified and if so, how?**

   As previously stated, Aviva would recommend that no minimum payment level be specified but that each insurer be allowed set the level themselves with the caveat that this must at least provide full coverage for the service/procedure in question within a pre-defined geographical area in at least one service provider. This would help ensure affordability as there would be no automatic base rate upping the payment levels, consumers would have full coverage and protection and it would allow insurers the commercial freedoms to negotiate the best possible rates with health care providers.

5. **What are your views on the possible approaches for simplifying the specification of minimum payment levels referred to earlier?**

   Please see response to Question 6 above.

6. **How should recent developments in healthcare and healthcare policy (including with regard to primary care and chronic disease management) be reflected in Minimum Benefits Regulations?**

   Aviva is supportive of any measures which seek to reduce the reliance on in-patient hospital services and which seeks to encourage healthy behaviours. In particular, there should be no perverse incentives for insurers to give preference to higher cost in-patient care if there are step-down community services available (i.e. if raising in-patient costs by a dominant insurer could raise the average claim cost and hence lead to greater risk equalisation payments).

   If healthy behaviours are to be pro-actively encouraged by insurers then there should be flexibility within the minimum benefit regulations to allow insurers to incentivise better behaviours. In particular, it might be of interest to do further research of the model developed by the South African insurer Discovery Health in encouraging its members towards better lifestyles within a community rated market.

   In addition, it must be ensured that minimum benefits do not provide any incentives towards health care providers or professionals to keep patients within a certain setting where other more suitable and equally clinically indicated options are available.

7. **Which primary care and chronic disease management services should be covered by Minimum Benefit Regulations and to what extent?**

If chronic disease management (CDM) programs were to be covered under this legislation, then the issue of the identification of members' pre disease and post disease onset must be addressed. This can be done via use of national disease registers or by the member completion of an information request at date of joining – which would in our opinion be inappropriate as it could leave to insures selecting members on the basis of health status

However assuming that persons have been identified as being likely to suffer from or have been registered as suffers of a chronic disease, then the issue of the selection of the most appropriate and cost effective disease to manage arises. Recent studies have shown that the most positive returns on CDM has been in the areas of

- Diabetes management (not prevention)
- Asthma Care
- Chronic Heart disease
- Multiples of the above

As previously stated in order to maximise the effects of such systems then insurers should be allowed to reward appropriate behaviours or cease to provide the service where there are repeated failures to properly engage and adhere to the programmes.

Primary care facilities should be covered to the extent that they provide an alternative service to that set out within a hospital setting. Again, however, insurers must be allowed the flexibility to engage with those facilities which it deems most appropriate within any given geographical area. A blanket coverage of primary care facilities would not enable insurers to maximise efficiencies through negotiations of rates and not all primary care facilities may have the skills to carry out all services.

In addition, care must be taken that the inclusion of primary care facilities does not by lead to a broadening of the level of benefits to cover all procedures within a primary care setting. Any such expansion of services would only lead to huge cost increases for consumers and insurers.

The inclusion of both chronic disease management and primary care benefits must be assessed against affordability for the more economically sensitive consumers within the market.

8. **Do practical issues arise with respect to including primary care benefits in Minimum Benefit Regulations? How would such issues be addressed.**

Firstly, if any of the benefits listed within the public hospital services can be provided within a as primary care or community setting then these should be included for coverage within the minimum benefits. However, again this should not mean automatic coverage for all primary care facilities within the State but should fall within the parameters of the geographic area to be covered by each insurer. Insurers could then determine on a case by case basis which primary care facilities, having reviewed their clinical standards and outcomes should be covered under each plan.

If the proposal is to have mandatory coverage of a prescribed number of routine primary care visits within each plan then this should be carefully examined as it will inevitably lead to a rise in costs. This will be even more pronounced if there is no element of co-payment towards the cost of a visit and if insurers are forced to cover all primary care/GP's within the State. Aviva would be supportive of some element of coverage for an annual specified health screening within a primary care setting.

9. **What are the consequences of including primary care and chronic disease management in Minimum Benefit Regulations**

Any new benefit that is set down within Minimum Benefit Regulation will have an automatic effect on costs. In particular, this cost will be felt most acutely on lower level plans which by their nature will have been purchased by more price sensitive consumers e.g Aviva has assessed that the inclusion of two GP visits within plans would cause a premium increase of between 7-10% on lower level plans. Therefore, prior to the introduction of any new benefit there must be a detailed cost benefit analysis carried out and this must be balanced against any possible negative effects on the size of the market as a whole. If premiums on lower level plans are pushed then this will accelerate the current contraction on the market and great an even greater burden within the public health system.

The affordability of health insurance is therefore crucial, while minimum benefits can be strengthen for consumer protection this will beneficially effect will be eroded if the market declines as a consequence.

While it is recognised that long term savings may accrue to insurers through the implementation of chronic disease management programmes and by strengthening primary care services and in particular health screenings current economic conditions mean there is no price flexibility to allow increase costs.

10. A significant requirement of the current Regulations relates to private care in public hospitals. Should the Regulations provide for a possible reduction in private services in public hospitals, if so how?

There should be no mandatory coverage of all public hospitals within the State and no mandatory costs prescribed yearly for bed days within such facilities. Each public hospital should be assessed on a case by case basis based on clinical outcomes and the negotiations of rates unilaterally with insurers. Once all services are provided within a set geographical area and the healthcare providers are properly accredited, then consumers have been protected and there is no need to (other than for commercial reasons) to cover all public hospitals in a region. There is also a vital need to ensure transparency within the public hospital system and in particular to have clarity on which beds are designated and a comprehensive list of Consultants and their categories. If this were to occur then insurers would have the commercial freedom to move patients into other facilities and away from public hospitals in alignment with the policy of the Minister for Health and Children.

11. How should Minimum Benefit Regulations recognise the interactions of private healthcare provision in public hospitals with provision in private hospitals and other private provision?

As stated above Aviva believes that maximum efficiencies can be gained by allowing insurers the capability to negotiate freely with all health care providers regardless of whether these are private or public facilities. Aviva would not support the mandating of coverage or rates with any particular provider as this guaranteed income does not allow insurers any powers to incentivise better clinical standards and outcomes or negotiate better rates.

While co-location facilities are intended to remove private patients from public hospitals this should not mean that insurers rights to choose which health care providers are covered should be eroded. In particular, Aviva would have grave concerns about being mandated to cover facilities which have yet to be built, without any personnel. While Aviva understands that the business plans of co-located facilities were elaborated based on the insurance rates supplied by the HSE no insurer participated or agreed that such rates would be payable. Mandatory coverage at mandatory minimum rates for such facilities would not only interfere with the commercial freedom of insurers but would also raise competition issues with other private health care providers.

As previously stated, Aviva would not support any distinction in treatment within the minimum benefit regulations between any health care provider, including any new co-location facilities.

12. How do the current Minimum Benefit Regulations impact on the efficiency within the health insurance and private healthcare markets?

There are two primary factors currently affecting efficiencies within the health insurance and healthcare markets, the first is the minimum benefit regulations and the second is the dominance of the VHI.

The biggest impact that the Minimum Benefit regulation has on efficiencies is within the public hospital system. Insurers have no capacity, and generally no notice, of the annual increase on bed rates set out by the Minister for Health in the Budget in December, which then becomes effective on the 1st of January. As such there are no contractual arrangements with any public hospital and no capacity to negotiate better rates, better outcomes or incentives to drive efficiencies through providers.

The small number of competitors in the health insurance market and the huge dominance of VHI places a disproportional dependence on all healthcare providers on VHI. No hospital within the State can survive without coverage from VHI and the level or otherwise of its profitability is entirely contingent on the level of cover VHI will determine for that hospital. This limits both the ability of health care providers to negotiate with the VHI and for competitors of VHI to negotiate with providers. VHI itself is also constrained, having previously been sued[1] by a hospital for abuse of dominance for failure to cover its facilities. Both due to historic reasons and the

[1] Dean v. VHI [1992] 2 I.R. 319

continued dominance of VHI the market norm has now been set that all insurers must cover all facilities, clinics and as many consultants as possible as VHI competes on the extent of its network of coverage. As such efficiencies, or driving competition between health care providers for contracts with insurers cannot occur while the market continues only to have three players and the dominance of VHI remains.

The Dutch health insurance market, which now offers universal coverage and is community rated has made most of its gains by allowing insurers negotiate freely with providers and making both private and public facilities compete for coverage with insurance undertakings. This can reasonably be achieved as there are in excess of 20 competitors in the market and a balance of differing market shares. In addition the Dutch competition regulator is charged with checking for abuse of dominant market positions and the creation of cartels that act against the consumer interests.

13. What impact would you expect the amendment discussed in this paper to have on economic efficiency within the health insurance and private healthcare market?

The overriding aim within any amendment should be to continue to protect consumers but without artificially adding costs within the system. Any mandatory coverage at a set rate of any benefit or service will automatically limit the negotiating power of insurers and hence reduce efficiencies. As such to the extent that insurers are allowed commercial freedoms to negotiate with healthcare providers and contractually reward or penalise certain behaviours then the maximum can be achieved through the system. However, full efficiencies gains will not be possible with only three insurers and where VHI has the power to unilaterally decide the economic viability of any healthcare provider.

14. **Do you consider that some changes to the Minimum Benefit Regulation are warranted in order to achieve more economically efficient provision of private health insurance or private healthcare, while providing the best healthcare outcome? If you do, please describe the changes that you consider are warranted**

    Yes, as stated above, Aviva would favour the removal of base rates of coverage and allow for set coverage within predetermined geographical areas.

15. **Do you consider that amendments to the Minimum Benefit Regulations are required in respect of maternity, psychiatric, addiction related or step-down nursing home care**

    Aviva believes that no amendment is required in respect of maternity, psychiatric or addition related benefits. Where step-down nursing home care is an alternative to in-patient care then this should be included within set parameters within the minimum benefit regulations however, health insurance should not act as a form of long term illness insurance or be seen as a substitute for the Fair Deal program operated by the Department for Health.

CONCLUSION

Aviva is supportive of reform to the current minimum benefit regulation in order to continue to ensure consumer protection. However, Aviva would have grave concerns about any amendment to the regulations which would increase costs at a time where consumers are extremely price sensitive.

Aviva would welcome the opportunity to meet with the Authority to discuss the submission and how best to achieve an affordable, consumer orientated and competitive health insurance market. Due to the complex nature of this consultation Aviva would support a second stage of consultation once more detailed proposals are ready from the HIA.