

## **Response to Consultation Paper on Minimum Benefit Regulations in the Irish Private Health Insurance Market**

### **Opening Remarks**

The Minimum Benefit Regulations in the Irish private health insurance market were primarily designed to protect consumers by giving them a degree of certainty regarding what their health insurance cover provided. The regulations would appear to have done this with reasonable success. However, the 1996 regulations are now substantially out-of-date in terms of monetary amounts that were not inflation-linked (combined with significant medical inflation in the interim) and in terms of the specification of medical procedures that have in some cases been superseded. However, it should be acknowledged that, in practice, insurers in the market provide cover significantly in excess of the levels specified in the current regulations. Nevertheless, the current consultation process is welcome and timely in light of developments and policy relating to the public healthcare system.

### **Updating and Simplification of the Regulations**

An update and simplification of the current regulations would be beneficial, particularly in terms of clarifying what consumers can expect to be included in their cover. The submission that The Health Insurance Authority made in 2005 to the Department of Health and Children regarding minimum benefits (HIA, 2005) included a suggestion to set minimum benefits for procedures in terms of either the full cost or a set proportion of the cost of the treatment, rather than specifying benefits in monetary terms. This is one possible way of simplifying the regulations.

The suggestion in the current consultation paper about incorporating all health services provided by the public hospital system, and requiring the monetary amount of cover to be equal to the lower of that charged by the public hospital or that charged by the private hospital also has merit. Since the public hospital system provides a wide range of health services, this would give insurers limited scope to provide benefits about the minimum level. However, the treatment available to consumers on various plans available in the market is already very similar (the main difference being the level of hospital accommodation provided) so in practice this would not be likely to lead to a significant change from the existing situation.

One potential issue with this approach however, is that if a particular service is not carried out in the public system, thereby not being part of the minimum benefit package that insurers must provide, then if insurers choose not to provide cover for it consumers will be left with no choice but to pay out-of-pocket for that service, which would likely render it unaffordable to many consumers.

Whichever method is used to set minimum benefits in the future however, it would be preferable if they were set in non-monetary terms. Setting benefits in monetary terms, as was done in 1996, can lead to minimum benefit levels going out-of-date, as has happened with the 1996 levels, or can raise issues of inflation-linking, which can in itself be inflationary, as was noted in HIA (2005).

The issue of excesses was raised in the 2005 submission (HIA, 2005), in which a suggestion was made to limit excesses to a set proportion of the annual premium. Since then however, concerns have been raised regarding the increased incidence of market segmentation, partly stemming from the increased differentiation between health insurance plans (see, for example, HIA, 2009). Excesses could be one way for insurers to differentiate plans and attract different groups into different plans, as low-risk lives are more likely to opt for excesses than high-risk lives.

It would therefore be preferable if excesses were limited, perhaps to a set proportion of the annual premium, as suggested in 2005, or perhaps prohibited entirely. Although the latter suggestion might be criticised for reducing consumer choice, as mentioned above too much product differentiation can be detrimental to the benefits of competition to consumers, as noted by, among others, Maynard & Dixon (2002) and Thomson & Mossialos (2007).

### **Coverage of Primary Care**

The suggestion contained in the consultation paper of including primary care in the new minimum benefit regulations has some merit. In particular, it would encourage more people to seek treatment at an earlier stage in their illness, rather than putting off visiting a primary care practitioner, leading to a deterioration in the illness to such an extent that hospitalisation is necessary. This would have the potential to lead to overall savings in the health system.

The Minimum Benefit Regulations, 1996 already contain a provision (in Section 6) that insurers will not be obliged to make payments for inpatient services that could have been delivered in a day case or outpatient setting, nor will they be obliged to make payments for day case procedures that could have been delivered in an outpatient setting. A similar type of provision could perhaps be considered in any new regulations, specifying that insurers would not be obliged to make payments for hospital services that could have been delivered in a primary care setting. However, the new regulations would need to specify that such services would be covered in a primary care setting. Furthermore, the structure of any such provision would need to be carefully considered in order to ensure that consumers would be covered for necessary treatment at some level. In this context, it should also be borne in mind that consumers surveys published by The Health Insurance Authority suggest that consumers consider payment for hospital treatment to be the most valuable element of their private health insurance cover. Therefore, any move that could be seen as reducing such cover (even though it would do so by reducing the need for such cover) should be carefully communicated to consumers.

The broadening of the minimum benefit regulations to encompass primary care will mean that benefits that were not previously covered by private health insurance contracts would be covered (notwithstanding the limited coverage currently provided by some plans and more generous coverage provided by other plans). In the long term, this is likely to lead to savings to the healthcare system and to insurers. However, in the short term, it is likely to lead to higher claims costs, which in turn will lead to higher premiums. Given the current contraction of the market, likely due largely to affordability issues, this should be taken into consideration when designing the new regulations.

### **Changes to the Provision of Private Care in Public Hospitals**

As noted in the consultation paper, the treatment of privately insured patients may take place in public or private hospitals. The designation of beds in public hospitals as private beds is one source of controversy regarding equity in healthcare in Ireland. The effective subsidisation of such beds by the State, through charging less than the full economic cost of such beds (albeit that this is being unwound) has also led to equity concerns.

In order to improve the equity situation of public patients relative to private patients, it would be preferable to have private patients treated in private hospitals wherever possible. An incentive for this could be built into any new minimum benefit regulations. However, this issue should not be treated in isolation from other changes in the wider healthcare arena in Ireland. Specifically, as alluded to in the consultation paper, the introduction of new consultant contracts means that, except in exceptional circumstances, consultants working under the new contracts in the public hospital system may only treat private patients on the campuses of public hospitals. Apart from co-located private hospitals, this means that such consultants will only be able to treat private patients in public hospitals. Therefore, over time, consultants working in private hospitals will be solely restricted to such private hospitals (the only dual-mandate consultants being those incumbents on the older contracts, which are no longer offered). It is possible therefore – though the likelihood is uncertain – that there may be a divergence of quality of care between the private and public hospital sectors. Any incentives to encourage treatment in such private hospitals would therefore need to be considered in this context.

### **General Economic Policy Considerations**

As mentioned in the consultation paper, the current regulations are structured in such a way that insurers have the option of contracting, or not contracting, with individual providers. This allows insurers to compete on the basis of provider networks. In practice, all three insurers in the open market in Ireland contract with the vast majority of providers. Any new regulations should continue to allow such scope for competition. However, if contracting becomes overly selective, to the detriment of consumers, as has happened in the United States

for example, then The Health Insurance Authority should have a remit to uphold consumer protection by ensuring adequate provider networks.

## **Other Issues**

The consultation paper mentions four particular areas in which amendments could be considered: maternity care, psychiatric illness, treatment related to drugs and addiction, and step-down nursing home care.

In relation to maternity services, suggestions have been raised in international research that private patients are more likely to have caesarean sections than public patients, and that the rate of caesarean sections is higher in private hospitals than public hospitals. In this context, the partial coverage by insurers in Ireland of normal vaginal deliveries can be contrasted with the greater cover for caesarean sections. Whether this is an issue that could – or indeed should – be addressed in the minimum benefit regulations is a matter for policy-makers, but this is an area in which further research may be required.

In relation to psychiatric illness, the current regulations specify that insurers are not obliged to provide cover for inpatient and day patient services for more than 180 days in a calendar year. However, the regulations also specify that insurers are not obliged to provide cover for treatment for psychiatric illness (other than for drug and alcohol related treatment) as an inpatient for more than 100 days. In the context of equity for patients with psychiatric illnesses, this would appear to be anomalous, and perhaps consideration could be given to equalising these benefits in the new regulations.

As a general comment, it should be noted that minimum benefit regulations, while providing some degree of consumer protection, only specify minimum benefits. Above the minimum benefit level, insurers are free to provide additional benefits, which may be used to engage in risk selection (also known as cream-skimming). This was noted by Van de Ven & Ellis (2000), who also argued that minimum benefits rather than standardised plans can lead to opportunities for insurers to engage in market segmentation, which is an issue about which the Authority has already expressed concern.

Therefore, consideration should be given to introducing a standardised plan or a set of standardised plans in the market. Although this would likely draw criticism as reducing consumer choice, as noted earlier a number of international experts have argued that a large number of similar but not identical plans can be confusing for consumers, can lead to a reduction in the potential benefits of competition, and can be used by insurers as a tool to engage in market segmentation.

## References

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