Submission to HIA on Minimum Benefit Regulations etc

Dear Brendan,

We refer to the above and to our meeting with you and Liam on 10th August 2010 which was interesting as regards all aspects of the medical insurance world – to that end we have put together a few issues that we would ask you to consider in drawing up new minimum benefits regulations etc. Some of the points we raise are not directly related to this particular exercise but are relevant to the overall picture of health insurance/risk equalisation and community rating etc.

1. The 180 days minimum benefit provision for hospitalisation is not justifiable or sustainable in this day and age particularly in the context of charges being in excess of €1,000 per day – this was tolerable in the days when per diem rates were £100 or less. It also flies in the face of the planned Primary Care in the Community concept. Therefore it should be reduced to say 100 to 120 days and be based on a "rolling year" concept rather than in any "fund year".

2. Currently insurers have to cover all public hospitals – this should cease and cover could be linked to the performance of the particular hospital as regards clinical outcomes. If Gov is talking of changing funding for public hospitals to a system based on performance it follows that the poorer ones should not automatically get the same bed rate as the better ones from private insurers.

3. There is an urgent need to introduce a “side room procedure” rate for all public hospitals who are currently charging “Day Care Rates” (€655 plus €75 semi private inpatient charge) for very minor procedures.

4. Current MRI rates in Public Hospitals are well out of line with the private market and should be part of the per diem rate as currently applies to all other services in Public Hospitals.

5. Health Insurers could consider benefits for health screening but it would need to be targeted at the right age group and focus on the likely health issue of that group – not a trawl across all age groups for all illnesses – should be confined to people in 50’s plus age group and for delivery in a primary care setting.

6. RMU’s to maintain all their current derogations within minimum benefits and be given a right to seek new ones from any radical changes to minimum levels.

7. Any new regulations must allow free movement of RMU members and dependants to and from the “Open Enrolment Insurers” – we did not seek to be excluded from the new Risk Equalisation Scheme (Department of H & C Proposal) and therefore our members and their families should not be penalised or excluded from the free movement provisions applying to everyone else.

8. The introduction of Primary Care in the Community is to be welcomed but insurers need to be satisfied that it will lead to a dramatic reduction in acute hospital care – in that context the insurers could provide minimum cover for a variety of procedures which could be carried out in this setting – they would need to be coded and a reasonable and competitive charge set for each one.

9. People with “Lifetime Illnesses” would have to be cared for in the State Hospital Sector as insurers could not price or sustain the cover required. Need to also ensure that access to new/special drugs are provided by the State for Lifetime Illness patients e.g. Tysabri for the treatment of MS and not held back thereby forcing private insurers to cover them as our members will demand it.

10. In any new regime, regard will have to be given to the fact that all citizens of the State have an entitlement to proper health care as of right including people with Private Health Insurance at great expense on themselves who have no entitlements and are being viewed as a burden on the Public System – this is unacceptable. This is an important point as all our members pay PRSI/Health Levy’s and are entitled to a public bed. Yet we pay over €900 extra to get a private room or €750 etc for a semi-private with no account taken or allowance made for our public bed entitlement.

11. We see merit in having certain procedure designated as normally carried out in a primary care setting e.g. Haemochromatosis (Phlebotomy) and Warfarin in return for Insurers agreeing to allow minimum benefits to apply for them. There are a range of small procedures that need never go to a hospital and we would be better off paying a GP for doing it in accordance with agreed codes and prices.

12. Urgent need to introduce an “age at entry premium loading” to encourage people to acquire medical insurance earlier – suggested age of 30 years.

13. Why should convalescence require a minimum benefit anymore? Less invasive surgery and heavy anaesthetics etc have changed the scene to shorter stays and any cover now should be optional to insurers?

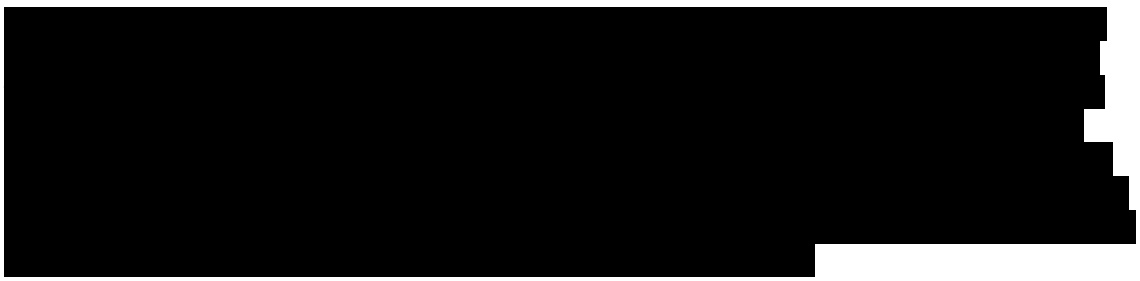
14. Why should consultant get a daily benefit no matter how long the stay? This is on top of his surgery fee etc. Is there a case for reducing anaesthetist fees which were originally based on the “heavy general” anaesthesia for everything

If you require any clarification on any of the issues raised, please come back to us.

Yours Sincerely

John Fahy **Dave McCabe** **Donal McAllister**

Addendum on behalf of ESB Staff Medical Provident Fund (MPF)



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Dave McCabe