THE HEALTH INSURANCE AUTHORITY

**Report of The Health Insurance Authority to the Minister for Health and Children pursuant to Article 10 of the Risk Equalisation Scheme, 2003 and for the period 1 July, 2003 to 31 December, 2003.**

**28 April, 2004**

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## Introduction

The Health Insurance Authority ("the Authority") is pleased to furnish this written report to the Minister for Health and Children ("the Minister") as required by Article 10 of the Risk Equalisation Scheme, 2003 ("the Scheme").

The report was compiled by the Authority following a careful evaluation and analysis of returns made to it under the Scheme pertaining to the period 1 July, 2003 to 31 December, 2003. As required by the Scheme, the report gives details of the evaluation and analysis carried out by the Authority and specifies the market equalisation percentage determined and the health status weight adopted for the purpose of the determination.

As the market equalisation percentage determined is between 2% and 10%, the report includes a recommendation on whether the Minister ought or ought not to exercise his powers under Article 13 of the Scheme and the reasons for the recommendation provided.

The report also contains information and advice concerning the carrying on of health insurance business, and developments in relation to health insurance generally, which the Authority considers ought to be included as a result of its evaluation and analysis.

## Background

Historical Background

The Health Insurance Act, 1994 provided for the opening of the health insurance market to competition. The Act included provision for the establishment of the Authority and for a risk equalisation scheme. BUPA Ireland was the first to enter the health insurance market following the Act and remains the sole competitor to Vhi Healthcare in Ireland in respect of the generality of the market.

Risk Equalisation Regulations were introduced in 1996 but payments were never commenced under them. Instead, the Regulations were subjected to significant analysis by an independent group, the Advisory Group on the Risk Equalisation Scheme. The then Minister for Health and Children also published a White Paper on "Private Health Insurance" in 1999, which set out the Government's policy objectives and proposals regarding the role of private health insurance in the overall healthcare system. During this time, the 1996 Risk Equalisation Regulations were revoked.

The Government's White Paper reaffirmed a recommendation by the Advisory Group that The Health Insurance Authority be established.

The Authority was established on 1 February, 2001 and its role, as set out in the Health Insurance Act, 1994 was amended by the Health Insurance (Amendment) Act, 2001. This legislation specified the Authority's responsibilities with regard to risk equalisation as well as providing that the Authority may advise the Minister on matters relating to the functions of the Minister under the Health Insurance Acts, 1994 –2003, the functions of the Authority and health insurance generally.

The Risk Equalisation Scheme, 2003

The Scheme came into effect on 1 July, 2003. The Scheme sets out the process under which any determination to commence risk equalisation payments would be made, as well as setting out the responsibilities of the Minister, the Authority and Scheme Undertakings. The Authority's role in relation to recommending, to the Minister, whether or not risk equalisation payments should be commenced is key. This role differs at three levels of risk difference between health insurers.

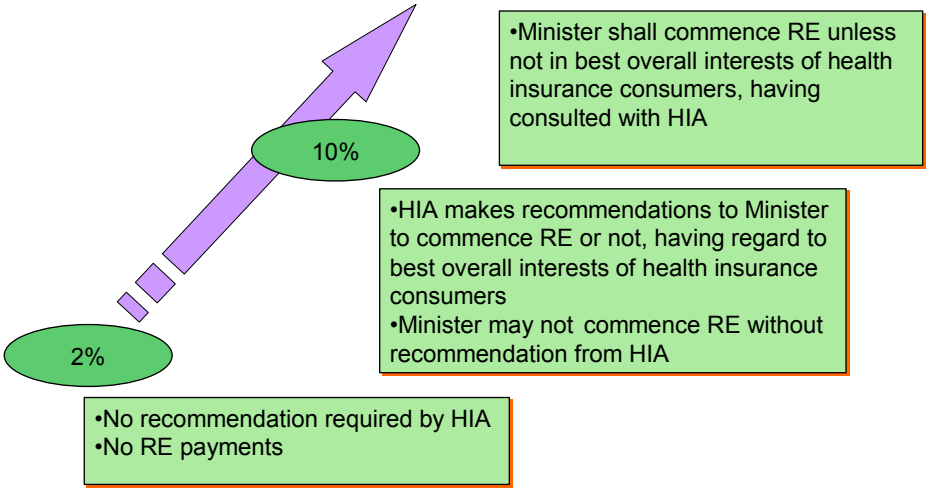
- If the level of risk difference between insurers is such that the Market Equalisation Percentage is below 2%, then a recommendation is not required from the Authority to the Minister and risk equalisation payments will not be commenced under any circumstances.

- If the level of risk difference between insurers is such that the Market Equalisation Percentage is between 2% and 10%, then the Authority is required to make a recommendation to the Minister whether or not to commence risk equalisation

having regard to the best overall interests of health insurance consumers. The Minister may not commence risk equalisation payments without a recommendation to so do from the Authority while the Market Equalisation Percentage falls between 2% and 10%.

- If the Market Equalisation Percentage is above 10% the Minister shall implement risk equalisation unless he believes it not to be in the best overall interests of health insurance consumers, having consulted with the Authority (referred to as HIA in the graph below).

Risk Equalisation Thresholds as per the Scheme




We see from the above diagram that the exact role of the Authority in relation to the Scheme is determined by the value of the Market Equalisation Percentage. However, this measure is by no means the sole determinant of the Authority's recommendation. The Scheme specifically states that the Authority's recommendation must have regard to the best overall interests of health insurance consumers, which includes a reference to the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings, and it is in this context that the Authority's deliberations took place.

Consultations

In preparation for its role in relation to the Scheme, the Authority has consulted widely with interested parties and has engaged in in-depth research in areas that are relevant to its recommendation.

The Authority issued a consultation paper in February, 2002 regarding risk equalisation in the Irish private health insurance market. This paper was distributed to

a large number of stakeholders including consumer groups, insurance undertakings, professional bodies, industry bodies, legislators and healthcare providers. Comment from a wider audience was invited through newspaper advertisements. The consultation paper requested comments on issues relating to risk equalisation and specifically on the relationship between risk equalisation and consumer interests, the circumstances in which risk equalisation should be implemented and the methodology that should be used.

In the interests of transparency the Authority decided to publish the responses received in relation to the consultation paper except when the individual / group responding specifically requested that the response not be published. Responses are published on the Authority's website at www.hia.ie.

Following consideration of the representations received, the Authority issued a Policy Paper, which was forwarded to you and your Department, in September 2002. In this Policy Paper the Authority stated that it was of the preliminary view that the introduction of risk equalisation could be justified in the appropriate circumstances. However, the Policy Paper went on to state that intervention may not always be appropriate to address difficulties in the private health insurance market and, where intervention is necessary, risk equalisation may not be the most appropriate, or even an appropriate form of intervention to use.

In its Policy Paper, the Authority also stated that, when deliberating on whether or not risk equalisation should be commenced in the best overall interests of health insurance consumers, it would consider, *inter alia*, matters such as

- the differences in risk profiles between insurers,
- the relative sizes of insurers,
- the age / sex profile of insurers' policyholders,
- the rate of premium inflation,
- the number of insurers in the market / new entrants to the market,
- the effect of any transfer on premiums payable by consumers,
- the overall size of the market,
- the effect of payments on the business plans or solvency of insurers and
- the commercial status of insurers.

Subsequent to the publication of its Policy Paper the Authority remained open to the views of stakeholders and interested parties.

Of course, the Authority now discharges its functions in accordance with the Scheme.

Research

The Authority has conducted, and continues to conduct, research into the health insurance market in Ireland and comparisons with overseas markets. This research covers issues including, *inter alia*, premiums, premium inflation and medical inflation, market size and growth, age profiles, the operation of community rating and risk equalisation, adverse selection, alternatives to private health insurance and the interaction between private and public healthcare systems.

The Authority has also commissioned two major research projects, which were undertaken by external consultants, with the assistance of the Authority where appropriate.

The first of these was a survey of consumers, which was undertaken in late 2002. The initial reason for commissioning this research was to assess the degree of switching by consumers between health insurers in the Irish market. In its Policy Paper on Risk Equalisation in the Private Health Insurance Market in Ireland, the Authority noted some difficulties that could arise in a community rated market, such as those that could result from price following and predatory pricing. The arguments in the Policy Paper included the hypothesis that younger (and therefore lower-risk) consumers would be more likely to switch provider than older (higher-risk) consumers. Evidence of this trend existed from other markets, but the Authority wanted to test this hypothesis in the Irish private health insurance market. The Authority broadened the scope of this research to include an examination of the reasons for taking out or not taking out private health insurance, the level of knowledge and understanding consumers have of the market and of their own cover, and the level of satisfaction among consumers.

This research showed that relatively few consumers (6%) have switched provider, although those who did tended to be younger consumers. The survey also revealed relatively low price sensitivity among consumers, a high degree of satisfaction, and a moderate level of understanding of consumers' own cover and of market concepts such as community rating, open enrolment and lifetime cover.

The second major research project commissioned by the Authority was an examination of competition in the Irish private health insurance market. The Authority is committed to taking account of competition in its decision-making processes, and is mandated by legislation to consider the facilitation of competition in its decisions on whether or not to recommend the commencement of risk equalisation payments. The Authority therefore believed that independent research into competition in the market would be beneficial.

Issues examined as part of this research included the current level of competition in the market, how that would be affected by risk equalisation, what impact risk equalisation would have on the likelihood of new competitors entering the market and what effects a change in the commercial status of Vhi Healthcare might have on the level of competition in the market.

**The Evaluation and Analysis of Returns**

On 30 January, 2004, in accordance with the requirements of the Scheme, the Authority received returns, for the period 1 July, 2003 to 31 December, 2003, from each of the three scheme undertakings; namely BUPA Insurance Ltd (trading in Ireland as BUPA Ireland), ESB Staff Medical Provident Fund and The Voluntary Health Insurance Board (trading as Vhi Healthcare). Each of the returns was accompanied by an independent accountants' report. The Authority also sought and received additional information (including, for example, financial information) in relation to the three scheme undertakings.

The Authority evaluated and analysed each return made to it and all three returns collectively, for the purpose of ascertaining the differences, if any, in the nature and distribution of insured risks among scheme undertakings. As required by the Scheme, a Health Status Weight ("HSW") equal to zero was adopted for the purposes of the evaluation and analysis. From the evaluation and analysis the Authority has, for the period 1 July, 2003 to 31 December 2003, determined the following:

The Total Market Insured Persons ("MIP(Total)")[1] is equal to 1,846,685
The Total Market Equalised Benefits ("MEB(Total)")[2] is equal to €316,877,620
The Market Positive Equalisation Adjustments ("MPEA")[3] is equal to €11,644,378
The Market Equalisation Percentage ("MEP")[4] is equal to 3.7%

The evaluation and analysis included consideration of each of the matters listed in the Authority's Policy Paper and above, as well as consideration of the extent to which any risk equalisation payments could involve the sharing of efficiencies. These matters were considered in the context of the best overall interests of health insurance consumers, including the need to maintain the application of community rating across the market for health insurance and to facilitate competition between undertakings.

The Authority wrote to all scheme undertakings on 5 March, 2004 giving notice of the fact that it proposed to recommend that the Minister not exercise his powers under Article 13 of the Scheme. By means of the notice, the Authority invited undertakings to make representations in relation to the nature of the recommendation that, in the undertaking's opinion, ought to be included in the report. The Authority received representations from all three scheme undertakings on 26 March, 2004. These representations received careful analysis and consideration and the Authority took account of them before finally deciding what the nature of its recommendation ought to be.

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[1] *The MIP(Total) represents the average of the number of persons insured with products that are subject to risk equalisation (excluding those serving initial waiting periods) at 1 July, 2003 and the corresponding number taken at 1 September 2003.*
[2] *The MEB(Total) represents the amount of benefit that is subject to risk equalisation that was paid by undertakings in the 6 month period*
[3] *The MPEA represents the amount of the transfer that would have been paid in respect of the 6 month period if risk equalisation were in force and no phasing applied to the payments.*
[4] *The MEP is equal to MPEA divided by MEB(Total).*

## The Recommendation

In light of its careful evaluation and analysis and having regard to "*the best overall interests of health insurance consumers"*, including *"the need to maintain community rating across the market for health insurance and to facilitate competition between undertakings*", the Authority recommends that the Minister ought not to exercise his powers under Article 13 of the Scheme (which relate to the commencement of risk equalisation payments).

The Authority makes this recommendation for the following reasons:

- There is insufficient evidence of a threat to market stability.
- The value of the MPEA, in the context of the level of premium paid in the market and the number of consumers in the market, is low. This is also reflected in the value of the MEP. As a result, the potential benefits that could accrue for health insurance consumers directly from the transfer of funds would appear to be small.
- In this context the potential benefits of commencing risk equalisation payments at this time are outweighed by uncertain competitive consequences, which could arise.

## The Authority's Future Deliberations

The Authority's recommendation is made in the context of the evidence currently available to it. This recommendation should not be understood as an indication that the Authority will not, in the future, recommend the commencement of risk equalisation payments. The Authority remains of the view that, in the appropriate circumstances, the best overall interests of health insurance consumers in a community rated market could be served by the commencement of risk equalisation payments.

Furthermore, the Authority recognises that further data (including more returns), which may provide a more complete picture, including an indication of the rate of evolution of the values of variables included in this report, will soon become available and will inform future deliberations. Given the importance of the decision and the other factors mentioned in this Report, it might be considered more prudent not to base a decision to commence risk equalisation payments on a single set of returns.

**Information and Advice Concerning the Carrying on of Health Insurance Business**

Sub-article 10(3) of the Scheme states that this report may contain "information and advice concerning the carrying on of health insurance business, and developments in relation to health insurance generally". Accordingly, the Authority wishes to apprise the Minister of a number of relevant matters and, where appropriate, provide advice.

The Health Status Weight (HSW)

The Authority attempted, insofar as is possible, to gauge the effect of the age and gender profiles, variations in health status within age and gender cells and other factors on the claim profiles of the scheme undertakings. While the Authority's analysis would indicate that there are differences in health status between the three insurers, the most significant differences exist between ESB Staff Medical Provident Fund and the other insurers. Nevertheless the apparent difference in health status between BUPA Ireland and Vhi Healthcare may also be considered material. This is evidenced by the fact that a HSW of 0.5 would result in a value of the MEP for the period in question of 4.0.

However, in view of the detrimental effect that increasing the Health Status Weight could have on competition in the market[5] and in view of the fact that the Authority has, as yet, only received one set of returns, the Authority does not propose to make a determination that the weight should be increased at this time. The Authority will continue to keep differences in claims experience within prescribed age and gender cells as between scheme undertakings under review, will continue to investigate the reasons for such differences and accordingly will keep the value of the HSW under review.

The opt out clause for restricted membership undertakings

The Health Insurance (Amendment) Act, 2001 includes a clause that allowed restricted membership undertakings (RMUs) to opt out of any Risk Equalisation Scheme.

Following its evaluation and analysis of returns the Authority is of the view that the effect of and the reasoning behind this clause should now be considered further and would welcome an opportunity to discuss this issue.

[5] Applying a weighting greater than zero to utilisation could potentially result in insurers sharing some efficiencies and cost savings.

Unfunded Lifetime Community Rating

The unfunded single rate community rating system in Ireland, under which the premiums of lower risk lives fund the claims of higher risk lives, can be vulnerable if the rate at which lower risk lives take out insurance declines materially. This vulnerability, which relates to the possible deterioration of the risk profile of the overall market rather than the risk profiles of particular insurers, is discussed in the The Report of the Advisory Group on the Risk Equalisation Scheme (1998), the White Paper on Private Health Insurance (1999) and the Authority's Submission to the Department of Health and Children on Lifetime Community Rating (October, 2002). While the introduction of unfunded lifetime community rating would not remove this vulnerability completely, it could reduce it significantly by encouraging people to become insured at an earlier age.

The Authority recommends that unfunded lifetime community rating, as allowed for in the Health Insurance (Amendment) Act, 2001, be introduced at an early date so as to strengthen the community rated private health insurance system.

## Technical Annexe: Working Experience of the Scheme

Consistency of Returns

Prior to returns being received under the Scheme, the Authority met with insurers in an attempt to clarify any possible differences of interpretation in relation to the Scheme, and issued numerous invitations to insurers to forward comments should issues arise in the making of returns. Differences in interpretation of definitions in the Scheme became apparent, and this led the Authority to issue guidance in relation to the making of returns.

Following receipt of returns from insurers, it became clear that an insurer experienced what it termed "serious difficulties" in interpreting the Scheme in respect of matters that had not previously been brought to the attention of the Authority despite invitations to do so. The insurer informed the Authority at this time that it had adopted its own interpretations in relation to these matters. Following analysis of the approaches adopted by the insurer the Authority, in some cases, came to views that were contrary to those expressed by the insurer. Furthermore, the insurer informed the Authority for the first time in its returns that it did not accept the Authority's guidance as to interpretation in one respect and that it adopted a different approach when compiling its return.

The Authority was unable to fully resolve these matters through discussions with the insurer prior to the compilation of this report.

It is a matter of concern to the Authority that not all insurers compiled the returns on the basis sought by the Authority and that this resulted in inconsistencies in the returns filed. While such inconsistencies were not of sufficient magnitude to affect the Authority's recommendation for this period, the Authority would stress the importance of returns being compiled on a uniform basis by all relevant undertakings.

While it may be considered useful to clarify the aspects of the Scheme that gave rise to the need for guidance from the Authority, the Authority does not consider that merely amending these aspects of the Scheme would be sufficient to ensure that returns are compiled on a consistent basis in the future. The Authority is of this view because it considers that further ambiguities or disagreements in relation to the interpretation of the Scheme may arise and any guidance issued by the Authority in relation to such matters could be ignored.

In order to ensure that returns are consistent among registered undertakings in the future, the Authority requests that the governing legislation be amended to include appropriate provision unambiguously authorising the Authority to seek information and returns from registered undertakings on a basis determined by the Authority in accordance with the Scheme and an obligation on registered undertakings to submit returns on the basis required. The Authority's actions in these matters would, of course, be subject to judicial review but that need not be expressly stated in the legislation.

Miscellaneous Proposed Amendments to the Scheme

As a result of the Authority's working experience of the Scheme to date and in the context of its work to endeavour to ensure consistency among returns filed, the following matters would appear to the Authority either to be anomalous or to be a cause of confusion amongst undertakings.

*Services provided by registered nursing homes*
It would appear, from the inclusion of registered nursing homes in the definition of "health services provider" and the exclusion of health services provided by a nursing home other than a registered nursing home from the definition of "prescribed health services", that it was the intention that prescribed services provided by registered nursing homes would be included in returns. The Authority considers that it would be appropriate to include certain services provided by registered nursing homes, for example, it would be appropriate to include a certain amount of step-down nursing home care where an insured person had received hospital treatment.

However, the definition of a claim combined with other definitions, in the view of the Authority, results in services provided by registered nursing homes being excluded from returns.

*The definition of a fixed price procedure*
The Authority considers that provisions of the Scheme relating to fixed price procedures would benefit from clarification. In particular, the Authority recommends that they be amended to clarify the situation with regard to extra accommodation or services that are provided with a fixed price procedure but are not covered by the "fixed price" agreed between the hospital and the insurer. For example a normal fixed price agreement might cover hospital accommodation for up to 7 days for a fixed price, with extra days requiring additional charges. Another example would be a fixed price procedure, which might cover the cost of a heart operation but does not include the cost of the prosthesis.

*The exclusion of orosurgical services*
The definition of "prescribed health services" excludes "dental, orosurgical or orthodontic treatment or consultation with a dental practitioner". This definition could have the effect of excluding all surgery relating to the mouth (including, for example, surgery for cancer of the mouth). It may have been the intention to only exclude treatment provided by a dental practitioner. If this is the case, in the view of the Authority, the relevant clause needs to be amended.

*The definition of a "health services provider"*
The Scheme defines a "health services provider" as "a publicly funded hospital, registered nursing home or hospital, private psychiatric hospital or hospital consultant as appropriate".

This definition has the potential to impact on competition between those that provide healthcare services. This potential impact results from the fact that if an insured person receives health services in a hospital the cost may be included in risk equalisation returns, however if they receive the services from, for example a treatment centre or a scanning unit, the cost may not be included in returns. This results in inappropriate incentives for insurers to provide the care through one or other type of provider and may in certain circumstances place a provider (who may be offering better value services) at a competitive disadvantage.

The Authority is of the view that consideration should be given to changing the definition of a "health services provider" to a more inclusive definition. Such a more inclusive definition may also require an amendment to the definition of a claim.

*The definition of a "day-patient day"*
The Authority is of the view that the definition of a "day-patient day" should be amended in order to clarify that it is not necessary for the insured person to be maintained in a bed in order for the day to constitute a "day-patient day".

*The definition of a "settled claim"*
The Authority would suggest that the definition of a "settled claim" could be amended to clarify that "hospital stays which have been taken into account under a previous settled claim" should only be disregarded in respect of the cell claim values returned.