Mr. Liam Sloyan,
Chief Executive / Registrar
The Health Insurance Authority
Canal House
Canal Road
Dublin 6

27th August 2010

Dear Mr Sloyan,

Attached is IHAI's submission on the Consultation Paper on Risk Equalisation.

Our submission is the commercial perspectives of IHAI member hospital CEOs. The IHAI had not engaged actuaries or other professionals to provide a more technical submission.

Our submission is in the form of an overview commentary; rather than in the format of answers to your specific questions. We have however, tried to address all of the questions asked.

We would be happy to clarify any aspect of our submission and to meet with the Authority if you so wish.

Yours sincerely,

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Alan O'Kelly
Director,
Independent Hospital Association of Ireland (IHAI)

Independent Hospital Association of Ireland (IHAI) Submission on the Consultation Paper (CP) on Risk Equalisation (RE) in the Irish Private Health Insurance (PHI) Market

The IHAI's views regarding the CP can be summarized as follows:

Overview

- IHAI agrees with the Government and the Authority (HIA) that an effective RE scheme needs to be introduced in the PHI market as soon as possible.

- Community rating (CR) in a PHI market with more than one PHI provider needs RE in order to function properly.

- RE is required to support the sustainability of the PHI market and its suppliers (including IHAI members).

- New transitional arrangements (TA) should closely approximate the effect of the full RE scheme as further delays will endanger the sustainability of the PHI market.

- An effective RE scheme needs to have robust legal footing and to be accepted by the majority of PHI market stakeholders as being fair/reasonable, transparent and relatively easy to implement.

- In this regard, the Authority is able to draw on the practical experiences of other health systems in successfully implementing and operating RE schemes.

- The RE scheme should apply fully to new entrants after a grace period of (say) 1 year.

- The RE transfers should take account of lifetime community rating loadings on an actuarial basis to be agreed between the PHI providers and the Authority, and take account of changes in minimum benefit regulations.

- The RE calculations should be made available to the PHI providers, on a basis where no commercially sensitive data are disclosed. The RE calculations and payments should be published in summary format.

Relevant Risk Factors

- In determining the most relevant risk factors; in addition to age and gender, the RE system needs to take account of health status.

- As discussed in the CP, there are a range of measures which can be used to provide a proxy for health status including Diagnosis Related (DR) and Resource Usage (RU), each with various advantages/disadvantages.

- IHAI believes that the appropriate basis to use (to determine such a proxy) is one which is soundly based, and is supported by data which is relatively easily available/verifiable.

- In our opinion, the benefits of RE outweigh any challenges in collecting/verifying the data required for such a scheme.

Treatment / Procedure Coding Systems (TPS)

- A rich source of DR and RU data, including drug costs, already exists within the PHI system. This is the treatment/procedure coding systems (TPS) used in reimbursing the hospitals and medical consultants.

- While the different PHI providers have different products and operating structures, their claims coding/payments systems are broadly similar.

- The existing TPS are not as detailed as the diagnosis related groups codes (DRGs) used by the Irish public hospitals and other RE schemes. However, the TPS may be adequate for the TA.

- TPS data for the Irish public hospitals is available via the hospital consultants claims to the PHI providers for insured work carried out in public hospitals.

Medical Trends, Costs and Efficiencies

- Medical advances enable ongoing reductions in in-patient hospital admissions and in average lengths of in-patient stays. This trend is accompanied by increased day-case treatments in hospitals, and treatments in the community/primary care and at home (e.g. Home-Care/Hospital in the Home treatments).

- PHI providers avail of these advances/trends to reduce hospital claims costs and to achieve efficiencies on an ongoing basis. In addition, PHI providers have started offering home-care packages and preventative education.

- While hospital treatments constitute the great majority of PHI claims costs at present, this is shifting from in-patient to out-patient claims, and from bed-night related to fixed price/package price reimbursement. Fixed/package pricing shifts the burden of any inefficiencies to the Independent hospitals (the Public hospitals charge a per-diem rate to the PHIs).

- As these trends accelerate, sufficient new data should become available to eliminate any historic data bias towards in-patient and hospital treatments.

- Detailed RU data which picks up the abovementioned medical trends and costs, is already available via the TPS data held by the PHI providers.

- RE will not provide full reimbursement for any inefficiencies in individual PHI providers (and in any event will involve delayed payment). Therefore, RE will not incentivise inefficiencies at PHI providers. Accordingly risk should be fully equalized.

- In the hospital sector very few if any ‘luxury benefits’ exist. For example; single rooms, which might be seen as a luxury, are often justifiable clinically (e.g. to reduce the risk of cross infection or to assist in accelerating recovery via a quiet environment).

Data Collection

- The data required to support the RE scheme should be determined by the Authority and should be provided in a standardized format in sufficient detail to facilitate verification. Following set up and initial operation of data provision and verification systems, ongoing execution of the system should not be onerous.

- Verification of data can be achieved by a combination of means such as PHI auditor certification, comparisons/analysis by the Authority, and Authority random checks.

- Use of TPS/DR data as discussed above would minimize the resource implications for the Independent and Public hospitals.

- While the different PHI providers have different products and operating structures, their claims coding/payments systems are broadly similar.

Primary care and Prevention measures

- Costs for primary care, preventative treatment/care, and care in the community/at home are currently not a material element of PHI providers' claims costs. Therefore their inclusion at present would not make a material difference.

- This issue can be reviewed over time if such costs become a material part of PHI claims costs.

Fixed Price Procedures

- Fixed price procedures incorporate the prices agreed for each element of the treatment (i.e. accommodation, technical fees, diagnostic tests etc). Therefore, they should not be treated any differently than non-fixed price procedures.