Response to the Consultation Paper on Minimum Benefits

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Centura welcomes the opportunity to make a submission in relation to the Consultation process on Minimum Benefits.

Background

Each health insurance contract must not provide benefits below a prescribed level known as the "minimum benefit". The rationale behind this requirement is threefold:

1. To maintain inter-generational solidarity within a community rated system.
2. To ensure that individuals do not under-insure in relation to health benefits
3. To ensure the continued availability of a broad range of hospital care perceived as a minimum of cover by the insured population.

Summary of Centura Recommendations

- In general terms, proper disclosure is a better form of consumer protection than a system of minimum benefits.
- Minimum benefits should be based on the cover provided to customers and not the reimbursement rates to providers of healthcare services.
- In order to reduce complexity and also in order to remove potential obstacles to innovation and competition, minimum benefits should be set at a level which is sufficient to pay for a required procedure in the lowest cost setting.
- The procedures to be covered should be those judged medically appropriate. The list of procedures to be covered should be reviewed under medical advice from time to time.
- It should be possible to promote products that provide more limited cover in terms of the range of procedures (or conditions) that are covered. For example, it should be possible to purchase a plan that covers critical illnesses such as heart disease or cancer, while excluding less critical conditions. The minimum benefits in those cases would be limited to covering the relevant parts of a general schedule of minimum benefits.
- It should be possible to introduce product innovations that are common in other health insurance markets (including community rated markets) such as policy excesses.

General Observations

The need for consumer protection?

The Minimum Benefits were put in place as a consumer protection at a time where the Irish health insurance market was opening to new entrants in the market. A form of consumer protection was deemed necessary as it was believed that Irish health consumers would expect a certain level of medical cover from their health insurance contracts. Due to the complex nature of health insurance contracts it was felt that consumers may not be in a position to determine whether appropriate benefits were being provided in a health

insurance contract. Accordingly, the Minimum Benefit Regulations were put in place setting out a minimum level of cover required in each health insurance contract.

Consumers are becoming generally more sophisticated when buying products. If consumers receive proper disclosure in relation to any product – including a health insurance product – they are consequently able to make an informed choice. Therefore minimum benefits should not be necessary under this heading. At a time when Irish consumers are being prompted by government to shop around and make informed decisions, minimum benefits have no place.

A greater level of proper disclosure and improved clarity of explanation to health insurance customers will more effectively address the need for consumer protection than the minimum benefit regulations in their current format.

Continuance of traditional products: stifling innovation

One of the purposes of the minimum benefits system is "to ensure the continued availability of the type of broad hospital care cover traditionally held as a minimum by the insured population".

Our view is that this purpose is inappropriate and is a clear deterrent to innovation and competition. Once consumers are properly and clearly informed as to the nature of their cover, there should not be a requirement that benefits are based on a dated product structure.

The original basis for the levels of Minimum Benefits: stifling innovation

The current levels of minimum benefits were patently based on the then current levels of cover provided by the lowest plan available on the market at the time of introduction of the regulations, and on the then current reimbursement rates for consultants. Perhaps the clearest manifestation of this is that under Schedule B of the regulations, 35% of special procedure costs must be covered: precisely the percentage covered under the market's lowest plan.

While this situation pertains, innovation is clearly stifled. Competitors and potential competitors are forced to imitate the products of the single dominant insurer. To remedy this situation, both the structure and the nature of minimum benefits must be changed.

The current basis for minimum benefits prevents innovation related, *inter alia*, to:

- specific conditions or procedures
- policy excesses

Minimum benefits as a support for the community rating system

We acknowledge that a certain level of minimum benefits is necessary to sustain community rating. Due to the other disadvantages as explained above, the level of

minimum benefits should be very simple in structure and should be a t the lowest level consistent with support for the system.

Centura Response to Specific Questions in Consultation Paper

Role of the Health Insurance Authority

1. What is the appropriate balance between prescriptive schedules and the discretion of the Authority?

   Our view is that prescriptive schedules of payments for procedures (e.g. for non-participating consultants) are not necessary. Minimum benefits must relate to the cover enjoyed by customers, not to the amounts paid by insurers to providers for their services.

   The White Paper sets out that in relation to consultants' fees the minimum benefit can be deemed to be either of the following:
   - The reimbursement rate applicable where the consultant is party to a fully participating agreement with the insurer;
   - The minimum amount which the insurer has determined to be payable for procedures of different kinds, on a non-participating basis and which it has notified to the HIA.

   However, in the case of the second option where the HIA deems that the amount notified is less than 75% of the lowest reasonable market cost for any specified procedure, the HIA at its own discretion set a higher amount which it deems to reflect such a level of reimbursement.

   Centura supports any amendment which may lead to the simplification of the extensive schedules currently prescribed in regulation. However, this must be balanced with the need for cost certainty in relation to reimbursement rates and the operation of a competitive market with flexible costing.

   Where the insurer has determined the minimum amounts payable for procedures for non-participating procedures it is believed the market and competition should be sufficient to regulate the reimbursement rates rather than the discretionary raising of costs by the HIA. Should the HIA have the discretion set out within the White Paper this could in effect lead to a harmonisation of the market and would stifle any possible innovation between the insurers. Where the market is transparent and flexible it would not be appropriate for the regulator to interfere in pricing, insurers should be able to have flexibility in relation to the minimum amounts it has determined payable on a non-participating basis.

   In a market already subject to extensive regulation which in itself restricts competition it does not seem appropriate to restrict competition further with interference in pricing arrangements.

In summary, Minimum Benefits should not be linked to reimbursement rates but should be concerned with cover for consumers. This would enable insurers to negotiate rates with private hospitals and consultants and all that would be required within the minimum benefits is that appropriate procedures be covered.

2. To what extent should the Authority be responsible for determining minimum benefits and reimbursement rates?

   The purpose of the minimum benefits regulations is *inter alia* consumer protection in relation to the benefits which they expect to received from their health insurance contract. Hence, any broad discretionary powers which may be given to the Authority to determine minimum benefit levels could lead to uncertainty from a consumer perspective in relation to their entitlements and how these may vary. Where a basic level of minimum benefits is determined by legislation the supervision of these minimum benefits should be sufficient to enforce the policy basis for minimum benefits without the need for discretionary powers. This leaves the market open to commercial and competitive forces that can build on the minimum benefit structure.

   In relation to reimbursement rates any unilateral discretion to alter reimbursement rates could impact upon the market whereby insurers have costed their premiums accordingly. Any discretionary power to alter these rates could lead to uncertainty within the market and a distortion of competition with a potential negative impact on consumers in the form of raised premiums.

   We do not believe that it is appropriate to include specific reimbursement rates as a part of minimum benefits. Referring to the purposes of the minimum benefits system, what is important is that people are covered appropriately. The regulations allow scope for insurers to provide care in approved centres. Extending this concept to include all providers of services implies that minimum benefits should deal with ensuring that customers are covered for the costs of treatment that they need. The costs of obtaining that cover then become the concern of the insurer who must ensure that there is sufficient availability of care.

Review of Minimum Benefits

3. Should any revised minimum benefits be inflation-linked?

   Our proposed approach would obviate the need for inflation-linking.

4. If so, what measure of inflation should be used?

   As noted above, our view is that this question should not arise.

Nevertheless, if inflation linking were to be imposed, it must be based on the consumer price index. Medical inflation is a consequence of innovation in medicine. It would clearly be inappropriate (and grossly inflationary) to link payments for the same procedures (etc.) to an index of medical costs that includes increases in costs driven by innovation.

5. Alternatively, should the minimum benefit levels be reviewed on a regular basis?

   Minimum benefits should be periodically reviewed in relation to the extent of cover and up-dated regularly to incorporate changes in good medical practice.

6. If so, how regularly should this review take place?

   Change in good medical practice is continuous. We suggest that a yearly review of this nature to reflect changes in appropriate content of the benefits would be appropriate.

7. Should minimum benefit reimbursement rates be set in non-monetary terms?

   As noted above, we do not believe that any rates should be set in monetary terms. Consumers are concerned with the extent to which they are covered. They are not concerned with the rates paid to suppliers of healthcare by insurance companies. Reimbursement rates are an unnecessary and exceedingly complex part of the minimum benefits structure.

8. If so, what measures should be used?

   N/a

Scope of Minimum Benefit Regulations

9. Are these exemptions from the minimum benefits regulations appropriate?

   The minimum benefit regulation did not apply to health insurance contracts that provided exclusively for ancillary health services. However, the Health Insurance (Amendment) Act, 2001 stated that health insurance contracts that provide solely for relevant health services should not be subject to minimum benefit regulations, this is a narrower definition than that contained within the regulations.

   As ancillary benefits are a differing type of benefit to that found within the general scope of those contained within the minimum benefit regulations it provides insurers with the opportunity to develop specific schemes which may encourage the general healthy well-being of the population through alternatives to hospitalisation. As ancillary benefits are subject to open enrolment, community rating and lifetime cover it would not appear necessary or appropriate for these to also be covered by minimum benefits. From a practical point of view as ancillary

benefits may encompass a broad range of differing services the application of the minimum benefit system could prove a disincentive to the offering of such schemes.

In essence, the policy consideration behind the Minimum Benefits regulations are to provide the consumer with a basic minimum level of cover in relation to specific services which the consumer would expect contained within a health insurance contract, in particular the cost of hospital treatment, any move to extent this to ancillary benefits would appear to be an extension of the policy and a move towards harmonisation of all benefits which may not be in the best interests of the consumer.

10. Should separate minimum benefits be applicable to health insurance contracts covering solely relevant health services?

    The White Paper did not recommend any extension to the scope of services covered under the Minimum Benefits Regulations. And in particular in relation to recommended that primary care facilities (which fall generally within the definition of relevant health services) not be included within the Minimum Benefit Regulations. The view was put forward that private health insurers should be allowed to promote primary care but that it was not necessary for the protection of the interests of the common good as reflected in the core principles of the private health insurance market. Centura would support this view and would not endorse any extension or putting in place of a separate minimum benefit regime for relevant health services.

11. Are there any other types of health insurance contracts that should be exempt from the regulations?

    As previously mentioned above, with greater consumer disclosure it should be possible to create type-specific products to deal with the possible individual needs of consumers. Minimum benefits if necessary could then apply to the type of product in question i.e. a maternity product, cardiac product etc. This type of product would enable greater consumer choice to purchase the types of products they are most likely to use. Of course, more general products encompassing a number of differing ranges of services could be provided.

Conclusion

Centura will welcome any amendment to the Minimum Benefit Regulations that leads to simplification and a reduction of disincentive to innovation. Centura believes that the basis of the Regulations should be altered and the emphasis should be on coverage rather than prescribed schedules of reimbursement rates.