



Consultation Paper on Minimum Benefit Regulations in the Irish Private Health Insurance Market

July, 2010

Introduction

The Health Insurance Authority

The Authority is a statutory regulator for the Irish private health insurance market. It was established in 2001 under the Health Insurance Acts 1994 to 2009. The principal functions of the Authority as provided for in the Health Insurance Acts include the following:

- to monitor the health insurance market and to advise the Minister (either at his or her request or on its own initiative) on matters relating to health insurance;
- to monitor the operation of the Health Insurance Acts and, where appropriate, to issue enforcement notices to enforce compliance with the Acts;
- to carry out certain functions in relation to health insurance stamp duty and age related tax credits and in relation to any risk equalisation scheme that may be introduced;
- to take such action as it considers appropriate to increase the awareness of members of the public of their rights as consumers of health insurance and of health insurance services available to them; and
- to maintain the “Register of Health Benefit Undertakings” and the “Register of Health Insurance Contracts”.

The Consultation Process

The Minister for Health and Children has stated that she considers that a broad review of prescribed minimum benefits in the regulated health insurance system is desirable. She has asked the Health Insurance Authority to consult in relation to minimum benefits to be provided by insurers.

This paper contains a brief background discussion on minimum benefits and relevant aspects of the health insurance system. A summary description of the current Minimum Benefit Regulations is followed by an outline of the issues that need to be considered in the consultation.

It is Government policy that a regulatory impact analysis should be undertaken with regard to most primary and significant secondary legislation which is to be implemented. This analysis shall have regard to the principles of Necessity, Effectiveness, Proportionality, Transparency, Accountability and Consistency. The Authority would welcome submissions that have regard to these principles. In turn, the Authority’s advice to the Minister will have appropriate regard to the principles.

Please submit a response by post or email to reach the Authority by 13 September 2010
to:

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Please note that the Authority is a listed body under the Freedom of Information Acts 1997 to 2003 and proposes to make all responses to this consultation paper publicly available.

Background to Minimum Benefit Regulations

The need for Minimum Benefit Regulations

The Irish private health insurance regulatory system is based on the key principles of community rating, open enrolment, lifetime cover and minimum benefit and aims to ensure that private health insurance does not cost more for those who need it most.

Under community rating, the level of risk that a particular consumer poses to an insurer does not affect the premium paid. In other words, everybody is charged the same premium for a particular plan, irrespective of age, gender and the current or likely future state of their health subject to exceptions in respect of children under 18 years of age, students in full time education and members of group schemes.

Open enrolment and lifetime cover mean that, except in very limited circumstances specified in legislation, health insurers must accept all applicants for health insurance and all consumers are guaranteed the right to renew their policies regardless of their age or health status.

The key purposes of the minimum benefit system, as outlined in the 1999 Government White Paper on health insurance, are “to maintain inter-generational solidarity within the community rating system; to ensure the continued availability of the type of broad hospital care cover traditionally held as a minimum by the insured population; to ensure that individuals do not significantly under-insure due to lack of proper understanding of the restrictions which, in the absence of a specified minimum entitlement, could apply to some types of policies.”

The rationale behind minimum benefits supporting inter-generational solidarity is that the specification of minimum benefits should prevent private health insurers from being able to design plans that would only be attractive to low-risk groups, as to do so could lead to the segmentation of risks and result in more comprehensive plans, which would attract high-risk groups, either costing more or not being available. This would be counter to the principle of community rating.

In addition to the above considerations, the Government has decided that the Minimum Benefit Regulations need to be amended to reflect better how healthcare is delivered in a modern context including the current plans for the public healthcare system. In particular, the Government considers that the emphasis on acute hospital care should be removed, and that minimum benefits should emphasise the trend towards primary care, care in the community and measures to promote health, including chronic disease management.

The 1996 Minimum Benefit Regulations

Section 10 of the Health Insurance Act 1994 (as amended) (“the Act”) provides for minimum benefits and for the Minister making Minimum Benefit Regulations. Minimum Benefit Regulations were introduced in 1996¹ and continue to apply, the only amendment in the intervening period being a technical amendment in 2005².

The Regulations cover in-patient, out-patient and day-patient services provided by publicly funded hospitals, private hospitals, registered nursing homes and hospital consultants. Services provided by other healthcare providers are not included in the Regulations.

Primary care treatment is not covered by the Minimum Benefit Regulations unless it is regarded as out-patient treatment and provided by a hospital or hospital consultant. Under the Regulations, an insurer may also limit the total of payments for out-patient services to a maximum of €29 in any one year.

There are various definitions in Section 2 of the Act and in Article 3 of the Regulations. Key definitions in the Regulations include “prescribed health services” and “appropriate health services”, which are important in determining services to which minimum payments apply.

Four schedules to the Regulations specify the monetary amounts of prescribed minimum payments, including lists of specific costings for specific procedures. The four schedules relate to the following:

Schedule A – Hospital Charges (in-patient and day-patient)

Schedule B – Special Procedures

Schedule C – Consultant’s Fees (in-patient and day-patient)

Schedule D – Out-patient

Payments are specified differently for public and private hospitals.

With the current Minimum Benefit Regulations, insurers have some scope to determine, on the basis of medical advice, whether benefits paid should be based on treatment performed on an in-patient, day-patient or out-patient basis. Insurers may also specify the healthcare providers whose services are covered.

¹ S.I. No. 83/1996 – Health Insurance Act, 1994 (Minimum Benefit) Regulations, 1996
<http://www.irishstatutebook.ie/1996/en/si/0083.html>

² S.I. No. 333/2005 – Health Insurance Act, 1994 (Minimum Benefit) (Amendment) Regulations, 1996 - <http://www.irishstatutebook.ie/2005/en/si/0333.html>

Need for review

Updating the Regulations

The Regulations were drafted in 1996 and require updating in terms of the monetary amounts and some medical and surgical practices specified therein. Since 1996, the consumer price index has increased by 50% and the health sub-index of the consumer price index has doubled. The key components of health cost inflation for hospital services (doctors' fees and hospital charges) have more than doubled.

Hospital charges have increased significantly since 1996. Among other effects, this has resulted in a disparity between the minimum benefit levels for private stays in public hospitals and private hospitals. Private bed charges are now €13 for semi-private accommodation in regional and major voluntary hospitals, which is the required level of cover for public hospitals in the current Minimum Benefit Regulations. In contrast, the minimum payment in respect of a daily bed charge in a private hospital is currently €71.41, when the list of special procedures in Schedule B of the Regulations does not apply.

In addition, there have been significant changes in some medical and surgical practices in the last fourteen years. New drugs have been introduced and some medical related technologies have either been introduced or significantly enhanced. There has been a substantial increase in the proportion of elective procedures done on a day-patient basis rather than an in-patient basis.

Consequently, the Minimum Benefit Regulations need to be reviewed in order to reflect changes in medical practice (including changes in the setting in which health services are delivered) as well as changes to the costs of health services.

Simplification of the Regulations

The current Regulations run to over 100 pages and include long tables of monetary amounts for specific procedures. It has been suggested that it would be beneficial to simplify the requirements by avoiding a detailed list of procedures.

Possible approaches that could be pursued include:

- stating that the prescribed minimum benefits would incorporate all health services provided by the public hospital system and that, in respect of hospital services, the required level of monetary cover would be the amount charged by the public hospital, or if lower, the amount charged by the private hospital for the service concerned (less permitted excesses);
- alternatively, assign a function to the Health Insurance Authority to determine/specify the specific services to be covered and the cost level to which they would have to be covered.

Questions

Q1 Which services should be included in Minimum Benefit Regulations, or alternatively, how should the benefits to be included in Minimum Benefit Regulations be determined?

Q2 At what levels should minimum payment levels be set, or alternatively, how should minimum payment levels be determined?

Q3 What measures are necessary to ensure that the list of services remains up to date with medical developments?

Q4 How should provision be made for future changes in the cost of health services?

Q5 Should excesses on claim benefits be provided for explicitly in the Regulations? In particular, should there be limits on excesses?

Q6 Should the manner in which minimum payment levels are specified be simplified, and if so, how?

Q7 What are your views on the possible approaches for simplifying the specification of minimum payment levels referred to earlier?

Coverage of primary care and consideration of the primary care strategy

The Government has decided that the Minimum Benefit Regulations need to be amended to reflect better how healthcare is delivered in a modern context including the current plans for the public healthcare system. In particular, the Government considers that the emphasis on acute hospital care should be removed, and that minimum benefits should emphasise the trend towards primary care, care in the community and measures to promote health, including chronic disease management.

Aspects of the delivery of public health services are currently under consideration, including with respect to the delivery of primary care services. For example, the Report of the Expert Group on Resource Allocation and Financing in the Health Sector³ made a number of recommendations relating to the provision of healthcare services and the Minister has stated that she will bring this Report to Government in the autumn. While some matters have yet to be determined, the trend toward greater healthcare delivery in primary care settings and the increasing emphasis on chronic disease management are already clear. In this context the Authority is inviting stakeholders to provide their views in relation to how Minimum Benefit Regulations need to be amended so as to reflect these developments.

In addition to new developments in medical and surgical practices, there have been significant changes in healthcare public policy since 1996, most notably the primary care strategy. A central feature of current healthcare policy is that primary and community care and medical assessment units will lead to a reduction in emphasis on acute hospital care. In addition, it is intended that some conditions that are currently treated in in-patient and day-patient hospital settings would be treated at primary care level. The primary care strategy applies to the entire population, not just the proportion of the population that have medical cards. In addition to the general primary care strategy, there are new policy developments for particular aspects of healthcare, such as, chronic disease management and care in the community, which would also be expected to result in the avoidance of some hospital admissions.

If increasing the emphasis on primary care results in illnesses being treated in primary care that used to be treated in acute hospitals, then the existing Minimum Benefit Regulations may no longer require that these treatments be covered to the same extent. This is because the minimum benefit payments for out-patient services are lower than for in-patient services and the Regulations do not apply in respect of treatments provided by many primary care providers. For example, in certain circumstances, drugs and other therapies could possibly be administered in a primary care setting even though the cost of the drugs could exceed many thousands of Euro in one year. Such drug costs come within the current Minimum Benefit Regulations when administered in an in-patient or

³ Report of the Expert Group on Resource Allocation and Financing in the Health Sector, 2010
http://www.dohc.ie/publications/resource_allocation_financing_health_sector.html

day-patient setting but mostly not if administered in a primary care setting. In this context, it can be argued that the Minimum Benefit Regulations need to be broadened in order to protect consumers against underinsuring for primary care services.

Increased provision of private services in primary care settings could also have a public finance impact if private patients were unable to claim private health insurance benefits for major and/or expensive drug treatments and instead they made a claim from the State drug payments scheme. It also needs to be considered what other impacts such developments might have on the public healthcare system, the public finances and numbers taking out private health insurance, depending on how consumers/patients would act.

Chronic disease management

Improving chronic disease management is an important aspect of current healthcare policy and the primary care strategy. Substantial potential outcomes are desired for better health, patient satisfaction and economic efficiency. Achieving the desired outcomes is likely to require significant adjustments in the manner in which different healthcare services are delivered and coordinated with each other. Such adjustments may also have significant implications for how those healthcare services are financed.

To the extent that one focus of chronic disease management is to minimise A&E admissions and acute hospital stays, this may include frequent health monitoring and treatment in primary care. Frequent visits to general medical practitioners and other primary care episodes can be expensive for people without medical cards. While some existing health insurance policies provide significant out-patient and primary care cover, claims are often limited by one or other contract term, e.g. by the number of visits allowable for a claim, the amount payable per visit, an overall primary care claim payout, etc. These limiting terms for primary care claims contrast with the relatively more open-ended public health system cover and private insurance cover for acute hospital in-patient stays. Such a contrast necessarily gives rise to a financial incentive for patients (especially those without medical cards) away from primary care and towards acute hospital stays. This emphasis on hospital care over primary care and chronic disease management, which is also apparent in the current Minimum Benefit Regulations, contrasts with overall Government policy on the provision of healthcare services.

The Authority wishes to consult with stakeholders in relation to how the Minimum Benefit Regulations should be amended to provide for chronic disease management. In this context, we would welcome consideration of the appropriate services that should be covered, including the role to be played by health professionals other than doctors, for example physiotherapists, specialist nurses or other professionals. The Authority would also welcome consideration of whether amendments to the Regulations are required to better reflect the role to be played by services such as disease prevention, screening, health promotion and rehabilitation.

Questions

Q8 How should recent developments in healthcare and healthcare policy (including with regard to primary care and chronic disease management) be reflected in Minimum Benefit Regulations?

Q9 Which primary care and chronic disease management services should be covered by Minimum Benefit Regulations and to what extent?

Q10 Do practical issues arise with respect to including primary care benefits in Minimum Benefit Regulations? How could such issues be addressed?

Q11 What are the other consequences of including primary care and chronic disease management in Minimum Benefit Regulations?

Changes to the provision of private care in public hospitals

Since 1996, there has been a significant change in the proportion of private healthcare provided in private hospitals rather than public hospitals. This change can be expected to continue in view of the increase in the number of private hospitals, the new “public only” consultants contracts and the co-location strategy. Consequently, it is possible that, in certain circumstances treatment as a private patient may only be available within a desired time frame in a private hospital or by a consultant with an appropriate contract in a public hospital some distance from the patient’s home. (Of course, all residents of the State are eligible to avail of treatment in public hospitals as a public patient.)

Also, as noted earlier, the terms of the Regulations relate differently to private treatment in public hospitals (where the full cost of accommodation in a semi-private must be covered) and treatment in private hospitals (where a fixed monetary amount must be covered). The Government wishes that this be reviewed in order to avoid any inappropriate incentives arising from the Regulations for insurers to provide treatment in one hospital sector rather than the other.

The issue arises in respect of Minimum Benefit policy whether, in this context, the requirement on insurers should be to provide cover for services within a geographical region, regardless of whether those services are provided in a public or a private hospital.

Questions

Q12 A significant requirement of the current Regulations relates to private care in public hospitals. Should the Regulations provide for a possible reduction in private services in public hospitals, if so how?

Q13 How should the Minimum Benefit Regulations recognise the interaction of private healthcare provision in public hospitals with provision in private hospitals and other private provision?

General economic policy considerations

An important economic policy consideration is that the regulatory provisions of health insurance do not unduly impact on economic efficiency in the provision of private health insurance or on the provision of healthcare services. It is important that health insurers have a strong incentive to manage claims and claims behaviour in the marketplace in a manner that is conducive to economic efficiency.

Within the overall objective of economic efficiency, competition policy has an important role. Minimum Benefit Regulations should be designed so as not to unduly or unnecessarily restrict competitive economic forces in the provision of either health insurance or healthcare services. In the current Regulations, Article 6 and Article 9, in particular, which provide scope for insurers in relation to determining which provider and which setting is covered, are intended to facilitate competition and general economic efficiency.

It should be noted that various healthcare policies are also designed to promote economic efficiency. An example is the primary care strategy. As well as having the social and healthcare objectives of improving patient experience and healthcare outcomes, the strategy is designed to improve economic efficiency in the consumption of healthcare services.

Questions

Q14 How do the current Minimum Benefit Regulations impact on economic efficiency within the health insurance and private healthcare markets?

Q15 What impact would you expect the amendments discussed in this paper to have on economic efficiency within the health insurance and private healthcare markets?

Q16 Do you consider that some changes to the Minimum Benefit Regulations are warranted in order to achieve more economically efficient provision of private health insurance or private healthcare, while providing the best healthcare outcome? If you do, please describe the changes that you consider are warranted.

Other issues

Important aspects of in-patient healthcare are treated separately in the current Minimum Benefit Regulations. It needs to be considered whether these aspects ought to be treated differently in any new or revised Regulations, and if so, how. These aspects are;

- maternity care
- psychiatric illness
- treatment related to drugs and alcoholism
- step-down nursing home care

Question

Q17 Do you consider that amendments to the Minimum Benefit Regulations are required in respect of maternity, psychiatric, addiction related or step-down nursing home care?

Consultation Questions

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Submissions and Queries

Stakeholders and interested parties are invited to address any or all of the questions and issues raised in this consultation paper, or any other relevant matters. Submissions should be submitted by post or by email to reach the Authority by 13 September, 2010.

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Any queries on this consultation paper, in advance of submissions, may be directed to Brendan Lynch, Head of Research, who can be contacted by telephone on (01) 406 0080 or by e-mail at brendanlynch@hia.ie.