Health Insurance Authority Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market

Response of QUINN-healthcare to the HIA's Consultation Paper 27th August 2010

1) Executive Summary

QUINN-healthcare supports and agrees with the principles of intergenerational solidarity, community rating, open enrolment and lifetime cover.

QUINN-healthcare believes that the publishing of the Health Insurance Authority's Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market (the Consultation Paper) can act as a means of commencing engagement with the stakeholders in the private health insurance market in order to collaboratively improve the current community rating support scheme.

QUINN-healthcare established a cross-team working group made up of customer facing team members, claims and provider experts, information specialists and actuaries to prepare its response to the Consultation Paper.

A fair and equitable community rating support / risk equalisation scheme should meet all of 6 core principles:

- *Genuine Consultation with all stakeholders and an inclusive approach will provide the best recipe for success*
- *Insurers have to be able to make a return on capital*
- *The objective of the scheme has to genuinely protect the principles of intergenerational solidarity and community rating within the market.*
- *The scheme has to be based on a standard product*
- *Unit cost of claims of the scheme should be calculated after luxury product and operational inefficiencies are removed*
- *The scheme has to be proportionate in order to protect intergenerational solidarity in the market*

A sustainable health insurance market requires equalisation to a standard, rather than luxury, product level. The equalisation of luxury products and benefits will result in higher premiums for all insured members in the market and results in the disproportionate scenario where less well off customers compensate those better off customers with luxury products. This is particularly dangerous in these recessionary times as it may put Private Medical Insurance (PMI) beyond the reach of many customers putting greater pressure on the public health system. Equalising luxury products will drive younger insured members from the market which will impact intergenerational solidarity.

QUINN-healthcare has considered with interest the comprehensive list of possible alternative health status parameters for inclusion within a community rating support scheme. In certain instances, the essential data required to reach firm conclusions is not available to QUINN-healthcare, despite the best efforts of our internal working group to access the required data. The consideration of alternative health status parameters for inclusion within a community rating support scheme should be accompanied by comprehensive and interactive collaboration with the Department of Health and Children and the Health Insurance Authority.

These collaborative efforts should produce and agree the detailed analysis and statistical models required to assess the suitability of any proposed amendments to the scheme. A community rating support scheme that's derived through such collaboration is the best way to ensure that a fair and sustainable Risk Equalisation Scheme (RES) results and that the scheme meets the Government's stated social solidarity goals for the market. It is also the best way to ensure that the community rating support scheme will find acceptance in the market place.

Any community rating support scheme should not encourage operational inefficiencies by promoting and rewarding the consumption of expensive inpatient resources over equally suitable, but more cost-effective, outpatient surgical and primary care treatment options. We agree with the observations in section 4 of the Consultation Paper on Risk Equalisation where it is noted that the inclusion of hospital resource consumption or Diagnostic Related Groups (DRGs) within any community rating support scheme will reward and incentivise less efficient hospitalisation options over primary care treatment and prevention measures. Such inclusion will reduce the incentive for insurers to control their own costs, thereby leading to increases in medical inflation and premium costs for all health insurance consumers in the market.

Any market regulations hoping to sustain intergenerational solidarity (by seeking to avoid the spiral of increasing premium costs and loss of younger members from the market) should not contribute themselves to premium increases and market instability. This is an especially important consideration due to current economic recessionary pressures forcing customers out of the Irish health insurance market entirely. As noted by Health Insurance Authority in their submission to the Oireachtas Joint Committee on Health and Children:

"in a community rated market based on intergenerational solidarity, retention of existing profitable members and an influx of new younger members are key to market stability. A significant acceleration of the declining trend this year could therefore have serious consequences for the market".[1]

For the regulation of the private health insurance market to operate fairly, it is essential for the regulations to establish a level playing field for market participants. The current market is not a level playing field. Vhi Healthcare, the dominant insurer in the Irish health insurance market, is not regulated by the same codes and standards as its competitors. Vhi Healthcare is not required to meet the same solvency levels that other health insurers are required to meet. Vhi Healthcare falls outside of Financial and Consumer regulations that apply to the other major insurers in the market currently. Vhi Healthcare, which ran its business at a loss last year, is currently giving away free health insurance for children across all of its products. These kinds of "free insurance" actions pose significant risks to the stability and sustainability of the health insurance market as a whole.

Market regulations fail to work if they do not apply to all players in the market equally. In so far as the market is not regulated equally for all insurers, this should be

[1] "Submission of the Health Insurance Authority to the Oireachtas Joint Committee on Health and Children", 14 December 2009, pg 5.

addressed in advance of the introduction of an amended community rating support scheme. In a press statement reported on 28th May 2010, Minister Harney accepted the challenge that the absence of an independent Vhi Healthcare posed to fairness of risk equalisation implementation:

"The fact that the Government is the owner of the VHI and requires its competitors to transfer resources to the Government's company means that we don't have an even playing field."

Any community rating support regulations need to work with EU law.

2) The Six Core Principles of a Fair Community Rating Support Scheme

The following 6 core principles should be applied if an equitable community rating support scheme is to be introduced.

1. ***Genuine consultation with all stakeholders and an inclusive approach will provide the best recipe for success***

   With a view to building a fair community rating support scheme for the Irish market, QUINN-healthcare looks forward to working on an inclusive basis with the Department of Health and Children and the Health Insurance Authority based on its response to the Consultation Paper on Risk Equalisation. We hope that this engagement would be conducted interactively with all stakeholders in the market. We are willing to engage in discussion with the Health Insurance Authority, the Department of Health and Children (and/or their advisors) and other representatives if appropriate.

   We believe it is vital to include certain attributes within any scheme that is being considered. We are willing to provide our own data and to present our analysis on the impact of this data to ensure that we arrive at an informed decision. We believe that to ensure that an effective scheme is arrived at, to the benefit of all customers in the market, overall market information and data in relation to membership profiles, claims experience and health status of members will need to be defined, gathered, shared and analysed by all parties in good faith.

   Issuing of the Consultation Paper on Risk Equalisation is in line with the undertaking that the Department and the Health Insurance Authority would engage in an extensive consultative process before any new scheme is put in place. We would see our response to the Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market as being a first, rather than a final, step on the road of genuine consultation.

2. ***Insurers have to be able to make a return on capital***

   The Barrington Report[2] contains significant detail about the importance for insurance companies of making a return on capital in order to maintain a competitive, sustainable market place. The Report notes that it was very difficult for insurance companies to make such a return in 2007 in the market place as it was.[3] It is important that any measures introduced to support community rating allow commercial insurers to earn the type of returns that are available by pursuing other investment opportunities.

[2] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007
[3] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 2

3. *The objective of the scheme has to genuinely protect the principles of intergenerational solidarity and community rating within the market.*

QUINN-healthcare supports the principles of intergenerational solidarity and community rating within the Irish health insurance market. Those who can afford health insurance least have to be protected and they should not be forced to subsidise more expensive, luxury schemes and/or to pay for inefficiencies within the market place. This is a particularly important consideration during the current economic recession where insurance premiums, price and affordability are directly contributing to the decline in the size of the private health insurance market. The younger and healthier insured people are most likely to give up health insurance based on affordability concerns. This in turn negatively affects intergenerational solidarity within the market. Any community rating support scheme must not be designed with a view to sustaining or protecting the position of Vhi Healthcare.

4. The scheme has to be based on a standard product.

QUINN-healthcare agrees with the conclusion of the Barrington Report that *"as a matter of principle, Community Rating should apply only up to a level of coverage which is deemed adequate for and by the major proportion of the insured population".*[4] The importance of equalising risk within the Private Medical Insurance market based on a mass-market, standard product rather than luxury products is outlined in detail below.

The scheme should not be based on elements that promote insurer operational inefficiency and higher costs for insured members. A significant portion of insurers' costs arise from the settings of treatment. Treatment settings can range from care in patients own homes (with supporting mechanisms in place) to primary care settings (such as GP surgeries and consultants' clinics) to outpatient surgical settings to inpatient luxury, hi-tech hospital accommodation. Medical best practice suggests that certain treatments can be more beneficially, from the patient's perspective, carried out in primary care settings rather than in inpatient settings. For example, supported services to provide certain chemotherapy treatments in patients' own homes in order to reduce the risk of patient infection that accompany hospital visits are being explored in the Irish market at present. Similarly, diagnostic and investigative procedures are often more conveniently and cost-effectively carried out in clinics on an outpatient surgical basis rather than within hospitals on an inpatient basis. The community rating support scheme should not subsidise and promote insurers to consume more expensive and less efficient treatment options. Doing so would promote insurer operational inefficiency.

Partial equalisation of the market works well with the standard product concept in that it can be used as a tool to ensure insurers control their costs, thus minimising medical inflation, the benefits of which can be passed to customers via lower premiums.

[4] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 12

5. Unit cost of claims of the scheme should be calculated after luxury product and operational inefficiencies are removed

The claims cost within the scheme should only be calculated based on claims costs of members who have purchased standard products. This will enable a standard product-based unit cost to be derived. This standard unit cost can then be applied to all members in the market to reflect a true cost of a standard level of cover.

In recognition for the inefficiencies in the market and to promote competition within the market, additional measures need to be incorporated into any future community rated support scheme to ensure that the costs of inefficiencies are removed.

6. The scheme has to be proportionate in order to protect intergenerational solidarity in the market

Any measure implemented to support community rating should not be funded by a fixed amount per insured member as is the case with the Interim Levy system. The current levy charges on an Essential Starter adult policy represent 49% of the premium for the policy. The same levy charge represents 8% of the premium charged for an adult member with a HealthManager Gold policy. This levy charge has a disproportionate impact on the cost of standard plans which are actually designed to cover the benefits outlined in the Minimum Benefits Regulations.

The fact that a flat levy of €183 per adult has to be applied to every adult member, regardless of level of cover, has made health insurance disproportionately more unaffordable for our members on our basic standard level of product. Should younger members on these products be forced out of the market following the increased economic burden of the flat-fee Levy, we feel that the measure ultimately may pose a threat to the principle of intergenerational solidarity.

The Interim scheme does not provide an equitable basis for funding a community rating protection scheme. A revised risk equalisation scheme should avoid such disproportionality.

The current economic climate is contributing to a reduction in size of the health insurance market. Therefore, regulations must be sensitive to the implications they have for premium costs and ultimately the affordability of health insurance, especially as they affect the participation of younger consumers within the market.

3) Department of Health and Children's and the Government's Objectives for a Community Rating Support Scheme

According to the Department of Health and Children's "Health Insurance Market Reforms – Questions and Answers" document[5]:

"The Government's objective [for the health insurance market], driving all decisions, is

- *to sustain a stable health insurance market that contains effective solidarity between the younger/healthier people and older/sicker people;*
- *to protect older and sicker people from being loaded with premium increases or more expensive policies solely because of their age and medical history.*

The Government is building a market

- *where insurance policies are appropriate for people's health needs and relatively affordable*
- *where policies are not priced for customers on the basis of age or medical history (the principle of community rating)*
- *where consumers' rights to purchase any policy and to switch company are protected (the principle of 'open enrolment')*
- *where consumers' right to stay covered from year to year is protected (the principle of 'lifetime cover');*
- *where competition brings innovation and benefits to consumers;*
- *where each company is regulated on a level playing field to comply with solvency, reserves and other requirements;*
- *where health insurance can be developed in a way that supports overall health policy objectives, i.e. best outcomes for patients, a high level of health status in the population, an increased role for primary care, fair access for all, and financial sustainability"*

QUINN-healthcare supports and agrees with the principles of community rating, open enrolment and lifetime cover. Likewise, QUINN-healthcare supports and agrees with the importance of competition, regulation and the overall health policy objectives for the market.

QUINN-healthcare supports the Government's stated objective for the health insurance market in relation to ensuring that the market provides insurance policies which are appropriate for people's health needs and relatively affordable. We feel we have provided excellent and innovative products by listening and responding to our customers' needs throughout our years of operation in the Irish market. We feel that our efforts to operate a high quality and highly efficient service for our members have enabled us to control costs and offer our excellent products at highly competitive prices to our members. In order for the Government to build a market where insurance policies are both appropriate and affordable, the objective of the community rating support scheme has to be proportionate as well as genuinely protecting the principles of intergenerational solidarity, as noted in section 2 of this paper.

[5] http://www.dohc.ie/issues/health_insurance/ "Health Insurance Market Reforms – Questions and Answers", Section 1, Page 2

The "Health Insurance Market Reforms – Questions and Answers" document states that "*the Government's view is that core, standard health insurance policies should be community rated.*"[6] In order to achieve the Government's stated objective for the health insurance market - the support of intergenerational solidarity and community rating - we believe that the Government has correctly identified the importance of management of the cost of "core, standard" cover within the market.

QUINN-healthcare supports this view and discusses the importance of building a fair community rating support scheme in the private health insurance market based on standard cover in section 4, below. The exclusion of non-standard, luxury products and benefits from community rating support scheme will support the Government's desire to support social solidarity within the private health insurance market, where costs of standard, and not luxury, benefits are shared between young and old, between the healthy and sick.

[6] http://www.dohc.ie/issues/health_insurance/ "Health Insurance Market Reforms – Questions and Answers", Section 1, Page 4

4) A Community Rating Support Scheme has to be based on a standard product.

The Barrington Report, which was commissioned by and prepared for the Minister for Health and Children, concluded that the Irish Private Medical Insurance (PMI) market was not one where participants could expect to earn a rate of return on capital employed which would be regarded as adequate for the insurance industry.

The Barrington Report recommended that Vhi Healthcare be regulated by the end of the first quarter of 2008, that consumer protection in relation to PMI should be overhauled and that the government should encourage increases in the size, market appeal, innovation and competitiveness of the PMI market as a component of a quality healthcare delivery system.

In relation to community rating protections and risk equalisation, the Barrington Report concluded that:-

"Community rating should continue to be applied to all insureds but only to those levels of their benefits that are deemed to provide adequate PMI cover by the majority of the insured population and not to the additional coverages for the higher levels of PMI; and a simpler, more limited, transparent and possibly, prospective form of Risk Equalisation should be introduced which would not be regarded as a subsidy to Vhi Healthcare".[7]

QUINN-healthcare finds this opinion persuasive. Section 4.2.2 of the Barrington Report is especially useful in understanding how the authors differentiated between "adequate PMI cover" and cover they deemed to be "additional coverages":-

"As we see it there are at least four generic levels of health care available to PMI subscribers:

***Level 1:** Basic coverages providing treatment in public hospitals;*
***Level 2:** Midrange coverages providing semi-private care in either public or private hospitals;*
***Level 3:** Upper level coverages providing private care in private hospitals; and*
***Level 4:** Top level coverages providing what many would regard as luxury facilities in top of the range private hospitals.*

While all PMI insureds are covered to Level 1 or Level 2, approximately 15% of those insured also subscribe for Level 3 and Level 4. Coverages tend to be defined principally in terms of hospital care provided, with ancillary benefits also ranging from basic to luxury levels.

The Group believes that as a matter of principle, Community Rating should apply only up to a level of coverage which is deemed adequate for and by the major proportion of the insured population (which would correspond to Level 1 and Level 2 above). Additional coverage in excess of Level 2 is appropriately risk-rated and

[7] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 2

should be capable of being freely priced by insurers. This would ensure that a standard level of cover would always be available to the population generally at a rate likely to be affordable, while avoiding cross-subsidies and potential instability in relation to higher cover levels.

The initial definition and ongoing review of a standard level of coverage up to which Community Rating should apply should be progressed on a consultative basis. We believe the views of the PMI providers, clinical professionals, the DOHC and the full range of stakeholders are relevant, and consultation should proceed both at a reasonable pace and with the fullest transparency. The consultation should also embrace the scope of benefits to be included in Risk Equalisation arrangements (see Section 4.3 below).

We do understand that a minority (estimated at approximately 5%) of insureds will as a result of this change likely either have to pay more for cover or to make use of lower-cost hospital facilities. On the other hand the change should make it possible for larger numbers of young and middle-aged insureds to take advantage of newer and higher-cost facilities than is at present the case."[8]

In Section 5.9, the Barrington Report describes the consumer benefits of standard products:

"Comparing competing products is difficult. The classification of PMI into four broad levels of cover, as set out earlier in this report, may assist identification of policies which are community rated. This should provide a guarantee that such policies all comply with the new Minimum Regulations which are to be drawn up in consultation with medical experts to ensure indemnification for adequate treatment of the most likely health conditions. Higher level plans, which are proposed as risk rated and as an elective additional layer of cover bolted on to a Community Rated policy, will then be subject to more individual product design by various providers, In relation to those policies which are Community Rated, and subject to Risk Equalisation transfers between policyholders across the market, the Financial Regulator should produce a product comparison chart which all providers are obliged to issue with renewals and new sales."[9]

The Barrington Report recommended that "Government should indicate its intention to consult with stakeholders on definition of a level of PMI coverage which should be the standard community rated cover. This consultation should also address the establishment of a continuing process for updating of the community-rated level and the maximum excess to be allowed. Legislation should be introduced to eliminate any constraints on pricing of coverage additional to the Community Rated standard."[10]

[8] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 12
[9] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 24
[10] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 34

QUINN-healthcare finds the discussion in relation to Community Rating within the Barrington Report to be persuasive. The Government has indicated that provision of affordable health insurance to the Irish market is central to their development of the health insurance market. We feel that the utilisation of standard products and benefits within any risk equalisation scheme, to the exclusion of luxury products, is essential to ensure that community rating protections can be implemented in a stable and sustainable manner.

The inclusion and equalisation of luxury benefits and products in a risk equalisation scheme would result in social solidarity measures being applied to luxury products. Such inclusion would result in price increases to standard cover products and services across the market in order to provide for equalisation of luxury benefits and their related claims' costs. Consequently, the costs of health insurance for members with more disposable income who purchase higher levels of luxury health insurance cover would be subsidised by members with less disposable income who purchase standard levels of cover. The principles of community rating and intergenerational solidarity do not require the cost of these luxury products to be equalised.

The inclusion and market equalisation of luxury benefits would breach the third and fourth core principles set out in section 2, above. Their inclusion would, in effect, lead to increased consumer costs where members with expensive and luxury plans receive cross-subsidies from members with standard levels of health insurance cover.

The Barrington Report proposes that luxury products can be underwritten outside of a community rated support scheme, stating that *"additional coverage in excess of Level 2 is appropriately risk-rated and should be capable of being freely priced by insurers"*. Underwriting luxury products in this manner would allow insurers to support the claims costs of such luxury products and benefits on their own merits within their product portfolios, pricing the luxury products according to market demand for the luxury cover they provide. This would allow consumers to determine if benefits provided by luxury products are worth the additional premium they would be required to pay. Importantly for consumers in the health insurance market, removing luxury products from the scope of any community rating protection scheme would better enable insurers in the market to control the cost and to ensure the affordability of community rated standard products. Also, luxury products attract higher premium than standard products. This higher premium can be offset against the higher claims' costs of the luxury cover these products provide, negating the need to include such products within a community rating protection scheme.

QUINN-healthcare believes that the majority of its members subscribe to standard products as laid out in the Barrington Report. We believe that customers throughout the private medical insurance market should not be adversely impacted by price increases triggered by a community rating protection scheme that seek to support luxury products and services as well as standard product benefits.

QUINN-healthcare would welcome the opportunity to work with the HIA to develop a robust, industry acceptable definition of a standard product as a means of supporting community rating protection and intergenerational solidarity within any risk equalisation scheme that may be introduced. The costs of luxury products and

benefits should be removed from any community rating support and risk equalisation schemes.

The Consultation Paper notes that: -

"a further complication in Ireland is that different products provide different levels of cover. For instance some products only provide cover for semi private rooms in a public hospital while other products cover private rooms in all private hospitals. Therefore, in part, expenditure differences will relate to product differences rather than health status differences. This issue might be mitigated by excluding higher levels of cover from the system or by only partially equalising differences in expenditure per insured person, as for instance in the Australian system."[11]

The incorporation of the notion of partial equalisation within any community rating support scheme is not mutually exclusive to the incorporation of the standard product, as set out above. In fact, partial equalisation is required to ensure that the community rating support scheme maintains an incentive for insurers to continuously improve operational efficiencies, to control costs and to ensure that these savings are passed onto their members in a competitive private health insurance market. For the market to operate efficiently, insurers need to be incentivised to reduce costs in order to control medical inflation. If community rating support schemes fully equalise all claims costs in the market, insurers lose the incentive to do deals to control costs and premium. They will rely on regulatory handouts instead. However, if community rating support schemes partially equalise claims costs across the market, insurers will be encouraged to reduce claims costs through robust provider negotiation and to eliminate operational inefficiencies. The community rating support scheme will then drive insurers to control costs. Any reduction in costs can be passed onto customers through reduced premiums, encouraging more customers to remain insured within the market, supporting intergenerational solidarity.

[11] "Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market", June, 2010, pg 20

5) Response to Appendix 1 – Questions asked in Consultation Paper

Section 5 reflects the considerations and responses of a QUINN-healthcare working group made up of customer facing team members, claims and provider experts, information specialists and actuaries. This working group analysed the Consultation Paper as presented, conducted analysis of the scenarios discussed in the Consultation Paper where possible, modelled what data it could obtain on the concepts introduced in the Consultation Paper and conducted further analysis of international solutions and directions being taken.

The working group was unable to obtain Irish market data (such as DRG data for the Irish market) in relation to a number of the areas tabled for consideration by the Consultation Paper. It is not possible to answer specific questions without the relevant data on which the answer must be based. Indeed, for one type of measure to be chosen over another where the relevant data is not available could lead to one provider being unfairly favoured over another. The group found some of the international experiences, such as how South Africa is working through its information analysis process, to be quite interesting.

Q4.1 What are your views on using underlying risk factors in a risk equalisation scheme?

The Consultation Paper's discussion of underlying risk factors accurately summarised the challenges that the introduction of such measures to a community rating protection scheme may cause. Challenges arise in relation to consistent application of categorisation between insurers. Even the more straight forward underlying risk factors, such as address, may present challenges in implementation.

Q4.2 What underlying risk factors should be used?

Factors considered within any risk equalisation scheme need to be easy to define, straight forward to implement and readily understandable. They need to be relevant to the health insurance market. Any risk equalisation scheme needs to be supported by quantifiable data sets, data sets that the industry are capable of producing without excessive costs being incurred. In so far as underlying risk factors may not be measurable, may be complicated or expensive to measure, or whose definitions may be unclear, such risk factors may not find market acceptance for inclusion within a community rating support scheme.

Q4.3 What data should be collected from undertakings in respect of underlying risk factors?

The existence of robust, trusted and reliable data is essential in order for risk factors and health status elements to be considered for inclusion within a fair risk equalisation scheme. During review of the consultation paper, QUINN-healthcare began the process of gathering and analysing data pertaining to risk factors and health status in order to assess their usefulness within a risk equalisation scheme. This process was particularly challenging. We concluded that a number of these data sets have not been published and were not accessible to us in order for us to form an opinion on the suitability of these measures. We concluded that market-wide, published data sets do not currently exist for most of the risk factors documented in the White Paper. We recommend that in order to determine the usefulness of risk factors or health status in a community rating support scheme, that market level data gathering and analysis

exercises take place. Models for alternative risk equalisation schemes can be built, published and socialised to market stakeholders. "Shadow" risk equalisation returns based on a short list of models should be completed for a period of time to enable both insurers and regulators to review and agree the proposed measures based on realistic data sets.

Q4.4 Should underlying risk factors be fully or partially equalised?
It is difficult to form an opinion on this question without access to detailed data derived from the health insurance market as a whole for each of the risk factors. The QUINN-healthcare working group found that data on these concepts were not readily available for the Irish market. Any fair community rating support scheme to be implemented should be:-

- based on the core principles we've described above;
- based on a standard product; and
- partially equalised in order to incentivise insurers to control costs.

Q4.5 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?
We agree with the observations noted within the consultation paper that it may be challenging to collect and audit risk factor and health status data. We agree that the lack of a universally accepted definition of some of the high level concepts will lead to implementation challenges. Inclusive collaboration on these definitions would be a good way to address differences of interpretation. Steps to verify data submitted to insurers by customers can add significant operational costs to data collection processes. QUINN-healthcare would be particularly wary of imposing burdensome steps on our members in the normal and routine administration of their policies. Particular challenges may arise in applying data produced by other entities and sources to the private medical insurance market. Nonetheless, we would expect that fair collection, measurement and audit of data as it applies to the health insurance market would be essential in order for any scheme based on these measures to reach industry acceptance.

Q4.6 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?
Subject to the constraints of competition law, a definition of the data being processed needs to be agreed by relevant parties so that they have a common understanding of what they are required to capture and process. Auditing of returns and data is also an industry accepted control, though the costs of such audits may increase depending on the complexity of the subject matter being reviewed. The audit requirements for a risk equalisation scheme should be considered when designing the scheme.

Q4.7 Would a risk equalisation system based on underlying risk factors (in addition to age and gender) be sufficiently effective in supporting community rating?
It is difficult to form an opinion on this question without access to detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above. The 6 core principles should be applied in order to

ensure that a sustainable, equitable and fair community rating support scheme be introduced.

Q4.8 What are your views on using diagnosis related risk factors in a risk equalisation scheme?
It is difficult to form an opinion on this question without access to detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above. We agree with the practical implementation comments made in the White Paper:-

"Coding and verifying that the coding is accurate and consistent between insurers might be a complicated and expensive process. It might also involve additional workload for hospitals. Issues may arise in the extent to which the insurers use DRG (Diagnosis Related Group) coding, whether it is used consistently between insurers and how DRG returns could be satisfactorily verified."[12]

These challenges aside, an inclusive detailed consultation process to determine whether DRG inclusion within a risk equalisation scheme would be a valid option would be essential. We agree with the consultation paper observation that market equalisation through DRG could promote an inpatient bias, driving up insurance costs for consumers in the market place. QUINN-healthcare would not support a scheme that promotes market inefficiency to the detriment of customers across the market.

Q4.9 What diagnosis related factors should be used?
It is difficult to form an opinion on this question without being able to analyse detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above. The Consultation Paper noted the complexity of options which could be considered here. Thorough market analysis considering opinions of Irish medical industry experts may be useful in order to arrive at an industry accepted position in relation to diagnosis related factors. The approach taken in South Africa whereby very detailed analysis is being conducted to assess and build a detailed list of appropriate DRGs appealed to our working group as a sensible way to ensure than an accurate, fair and inclusive solution is designed.

Q 4.10 What data should be collected from undertakings in respect of diagnosis related factors?
Any consideration of DRGs should include claims coding based on industry standard codes, such as through use of ICD (International Classification of Diseases) coding.[13] Industry standards would be required to ensure that data is categorised and reported accurately and consistently between insurers and providers. Without an inclusive consultative process to explore this area in detail, the use of DRGs within any RES scheme may not reach industry acceptance.

[12] "Consultation Paper on Risk Equalisation in the Irish Private Health Insurance Market", June, 2010, pg 18
[13] ICD-10 was released by the UN World Health Organisation in 1994. The adoption of ICD10 coding for health providers and health payers is being actively promoted in the US currently

Q4.11 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?
Any consideration of DRGs should include claims coding based on industry standard codes, such as through use of ICD coding. Industry standards would be required to ensure that data is categorised and reported accurately and consistently between insurers and providers. Without an inclusive consultative process to explore this area in detail, the use of DRGs within any RES scheme may not reach industry acceptance.

Coding discretion and interpretation could pose significant challenges in collecting the data. Auditing of any coding and categorisation may be relatively expensive due to the complexity of the decision making process within claims diagnosis and treatment coding. Suitable skill sets will be required to undertake these audits.

Q4.12 Do issues arise for private and public hospitals?
As indicated in the consultation paper, challenges and costs could arise for all participants in the market in terms of having to implement or change claims coding categorisation processes.

Q4.13 How can confidence be established that the data returned is provided on a consistent basis by each of the insurers? What are the costs of establishing such confidence?
A definition of the data being processed needs to be agreed by relevant parties so that they have a common understanding of what they are required to capture and process. Auditing of returns and data is also an industry accepted control, though the costs of such audits may increase depending on the complexity of the subject matter being reviewed, such as medical DRGs. The audit requirements for a risk equalisation scheme should be considered when designing the scheme.

Q4.14 Should the differences in costs between different diagnosis risk factors be fully or partially equalised?
It is difficult to form an opinion on this question without being able to analyse detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above.

Q4.15 Would a risk equalisation system based on diagnosis related risk factors be sufficiently effective in supporting community rating in the best interests of consumers?
It is difficult to form an opinion on this question without access to detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above. The 6 core principles should be applied in order to ensure that a sustainable, equitable and fair community rating support scheme be introduced.

Q4.16 Should insurers provide the data at a DRG level or at a DRG Category level?
It is difficult to form an opinion on this without access to detailed data for each of these risk factors based on the health insurance market profile and data. We concluded that any selection of certain DRGs or DRG categories for special treatment

within a community rating protection scheme should be performed as a result of a comprehensive assessment of the operation of DRGs or DRG categories within the Irish health insurance market as a whole.

Q4.17 How would you adjust the DRG approach in order to avoid a bias towards hospitalisation where effective treatments outside of hospital are available and to allow for the rewarding of appropriate use of preventative medicine / treatments?
It could be very difficult to achieve this adjustment once DRGs are included within a community rating support scheme. If an objective of Government's health policy is to support and encourage primary care and preventative medicine, QUINN-healthcare would recommend that any RES scheme should avoid incentivising inpatient treatment over primary care. QUINN-healthcare would not support a scheme that promotes market inefficiency to the detriment of consumers across the market.

Q4.18 What are your views on using resource usage related risk factors in a risk equalisation scheme?
Any risk equalisation scheme that rewards consumption of medical resources (such as drugs or bed nights) over the control of such costs by increasing equalisation payments in line with increased consumption will result in increases in the overall health care costs across the market. Consumer premium across the market will increase as a result. This would threaten intergenerational solidarity and the Government's stated objective of providing affordable private health insurance within the market. As such, these proposals were not persuasive.

Q4.19 What resource usage factors should be used?
These factors were not persuasive. They do not encourage efficient operations within the health insurance market.

Q4.20 What data should be collected from undertakings in respect of resource usage factors?
These factors were not persuasive. They do not encourage efficient operations within the health insurance market.

Q4.21 Should the differences in costs between different resource usage risk factors be fully or partially equalised?
The bed nights and drugs factors were not persuasive. They do not encourage efficient operations within the health insurance market.

Q4.22 Would a risk equalisation system based on resource usage related risk factors be sufficiently effective in supporting community rating?
These factors were not persuasive. They do not encourage efficient operations within the health insurance market.

Q4.23 This consultation paper has suggested some possible measures of health status (underlying risk factors DRGs, hospital utilisation etc) that could be used in addition to age and gender. Are there other measures that might be adopted?
As noted above, QUINN-healthcare agrees with the conclusion of the Barrington Report that *"as a matter of principle, Community Rating should apply only up to a level of coverage which is deemed adequate for and by the major proportion of the*

insured population". The importance of equalising risk within the PMI market based on a standard product rather than luxury products is outlined in detail above.

Q4.24 Is it necessary to use more than one health status measure in a risk equalisation system, in order to ensure that it is effective in supporting community rating?

It is difficult to form an opinion on this question without access to detailed data derived from the health insurance market as a whole for each of the risk factors. Any fair community rating support scheme to be implemented should be based on the core principles we've described above.

Q 5.1 To what extent should costs incurred in providing primary care, preventative treatment / care and care in the community be included in the system?

QUINN-healthcare believes in providing primary care, preventative treatment and care-in-the-community benefits for our members. We have a number of active initiatives in place and are developing products and benefits around primary care treatments and medical best practice. We see the move to primary care setting as being essential in order to provide our members with best practice medical treatment and to control premium costs for our members. We believe that there are competitive and commercial incentives already in existence within the market to ensure that these services are provided for. We do not believe that incorporation within a community rating support scheme is required to drive the adoption and promotion of these services.

Q 5.2 How should the limits be set so as to exclude what may be regarded as luxury benefits? How should these limits be updated / kept under review?

As noted above, QUINN-healthcare agrees with the conclusion of the Barrington Report that *"as a matter of principle, Community Rating should apply only up to a level of coverage which is deemed adequate for and by the major proportion of the insured population"*. The importance of equalising risk within the Private Medical Insurance market based on a standard product rather than luxury products is outlined in detail in section 4 above.

The incorporation of the notion of partial equalisation is not mutually exclusive to the incorporation of the standard product within any community rating support scheme. In fact, we feel that partial equalisation is required to ensure that the community rating support scheme maintains an incentive for insurers to continuously improve operational efficiencies, to control costs and to ensure that these savings are passed onto their members in a competitive private health insurance market. We concur with Barrington Report recommendation that the proportion of benefits subject to equalisation be addressed through inclusive consultation.[14]

[14] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 16

Q 5.3 Should fixed price procedures be subject to different limits than other forms of treatment? How should fixed price procedures be defined?
Limits have a place in any community rating support scheme to ensure that the costs of luxury benefits and products are excluded from the scheme. These limits also act as incentives for insurers to operate efficiently.

Q6.1 What are the views of stakeholders in relation to this approach?
QUINN-healthcare is not in favour of continuing the tax based loss compensation system in its current guise. In our view, the current interim scheme has the following deficiencies: –

- the reliefs are disproportionate;
- the reliefs over-compensate;
- the calculation of cost per age band is distorted by the mix of luxury plans;
- the use of a fixed charge levy is a disproportionate cost on lower level plans;
- the methods applied in removing the premium plan costs from the calculation of claims costs are not sufficient;
- the impact of the levy on lower level plans and younger lower income age groups will result in a contraction of the market putting a greater burden on the remaining participants. Therefore the measures actually threaten intergenerational solidarity; and
- Our ability to neutralise the impact of the measures by changing the age mix of our book is curtailed by the fact that the dominant player has refused to participate in consumer awareness measures introduced by the state.

QUINN-healthcare would welcome effective solutions from the Department of Health and Children and the HIA that address all of the concerns listed above. Such solutions must ensure that:-

- product differences and inefficiencies are not compensated;
- meaningful consumer awareness material is provided by the dominant player in the market; and
- the scheme no longer operates in a manner that threatens intergenerational solidarity.

QUINN-healthcare hopes to work on an inclusive basis with the Department of Health and Children and the HIA in order to achieve these improvements.

Q6.2 What type of data would be necessary under this approach in order to assess the extent to which differences in claim costs for each age group between insurers arise from health status differences or from other causes?
QUINN-healthcare is not in favour of continuing the tax based loss compensation system in its current guise. The weaknesses identified in the current interim tax based loss compensation solution should be addressed in advance of any further refinement being undertaken.

Q6.3 Would it be possible to adapt this kind of approach when designing a robust system? How would this be done?

QUINN-healthcare is not in favour of continuing the tax based loss compensation system in its current guise. The weaknesses identified in the current interim tax based loss compensation solution should be addressed in advance of any further refinement being undertaken.

Q7.1 Should the system include special provisions for new entrants? How should these provisions be framed?

The Barrington Report noted that *"the non-application of Risk Equalisation transfer requirements to new entrants for a period of over three years following entry was a crude form of incentive which tended to further distort the market and, in our view, has appropriately been eliminated. We believe that it is sustained competition over the medium- to long-terms which should be encouraged in the manner set out above"*.[15] It should be possible to apply a fair and effective community rating support scheme to all participants in the market, encouraging participants to consider medium to long term returns for their investment.

Q7.2 Should the risk equalisation transfers take into account the amount of lifetime community rating loadings that an insurer receives and if so, how should the transfers incorporate these loadings?

It is difficult to form an opinion on this question without being able to analyse detailed premium data derived from the health insurance market as a whole. Any fair community rating support scheme to be implemented should be based on the core principles we've described above. It may be possible to consider premium income within an effective and fair risk equalisation scheme.

Q7.3 How should the new risk equalisation scheme take account of changes in minimum benefit regulations?

QUINN-healthcare is preparing a separate detailed response to the Health Insurance Authority's consultation paper on minimum benefits.

Q7.4 Should the risk equalisation calculations of the Health Insurance Authority be published?

QUINN-healthcare welcomes the opportunity of working with the Health Insurance Authority at a detailed level in order to agree which parts of the risk equalisation calculations can be published while, at the same time, respecting the commercial sensitivity of this type of material

[15] "A Business Appraisal of Private Medical Insurance in Ireland", a report for the Minister for Health and Children by the Private Health Insurance Advisory Group, March 2007, pg 16

Conclusion

QUINN-healthcare has answered the questions posed in the Consultation Paper as far as we can. A fair and equitable community rating support / risk equalisation scheme should meet all of 6 core principles:

- *Genuine Consultation with all stakeholders and an inclusive approach will provide the best recipe for success*
- *Insurers have to be able to make a return on capital*
- *The objective of the scheme has to genuinely protect the principles of intergenerational solidarity and community rating within the market.*
- *The scheme has to be based on a standard product*
- *Unit cost of claims of the scheme should be calculated after luxury product and operational inefficiencies are removed*
- *The scheme has to be proportionate in order to protect intergenerational solidarity in the market*

We look forward to working with the Health Insurance Authority and the Department of Health and Children on a collaborative basis to design and implement such a system.