Submission of

Vhi Member's Advisory Council

to

The Health Insurance Authority (HIA)

Consultation paper on:

Risk Equalisation in

Irish Private Health Insurance Market

September 2010

Vhi Members Advisory Council

1. The Vhi Healthcare Members' Advisory Council is recognised as the body representing Vhi Healthcare Members' interests on all health funding and insurance matters and is free to respond internally and externally on health funding and insurance issues as appropriate.

2. The Council is briefed regularly and as appropriate on Strategy, Policy and Performance.

EXECUTIVE SUMMARY

1. We support the key principles of community rating, open enrolment, lifetime cover and minimum benefits.

2. Community rating has broken down as can be evidenced by market segmentation that sees over 200 different health insurance plans on offer. That number is set to rise.

3. We support the concept of lifetime community rating.

4. Currently lower price plans are being aimed at the younger age cohorts. The elderly are being deliberately marginalised. This will only worsen unless some form of 'risk equalisation' that is 100% effective is implemented very soon.

5. The previous Risk Equalisation Scheme (RES) was struck down by the Supreme Court on the basis of an incorrect statutory interpretation of the term 'Community Rating' in the Health Insurance Act 1994. Therefore it follows that the Supreme Court judgement must be legally addressed before it is possible to design an effective and robust risk equalisation system to replace the current interim mechanism.

6. We believe that there should be a small number of communities that are based on the level of hospital accommodation used [(a) day care/side room (b) semi private (c) private] and, the hospital type [(i) private or (ii) public]. A maximum of six communities.

7. Interim measures have the capacity to act as an effective risk equalisation mechanism. The rates are the critical element. Bottom line is quantum of cash transfers.

8. Whatever risk equalisation mechanism is established if it is to be effective it must be set up to give 100% equalisation. Anything less will likely result in market segmentation, a move that will result in higher premiums for the older age groups.

9. Risk equalisation should be limited to acute in patient care treatments.

10. All inpatient benefits payable on the 'Community' plans (see 6 above) should be equalised as paid except for (1) excesses where the excess should be added back to the payment for risk equalisation computation purposes and (2) maternity where we recommend equalisation at 90% of the actual benefit payable/paid.

11. We suggest that if the proposed communities are separately equalised it may be that the factors to be used in the risk equalisation calculations age and gender only may be adequate. However, data over last five years should be back tested by the HIA for validation.

12. The risk equalisation fund will be administered by the Regulator and payments into the fund will be based on the payers average claims cost as adjusted for excesses.

13. Returns based on assessments (not payments) to be made quarterly and to be subject to external audit. Option to have quarterly payments and say half yearly audits.

14. Terms like high tech and luxury should be dropped as they are out dated and misnomers.

15. Primary care and preventative care costs that members can fund themselves should be excluded from risk equalisation.

16. The risk equalisation fund should be self financing with payments out restricted to maximum of receipts in.

17. The lack of an effective risk equalisation mechanism will lead to market segmentation and ultimately price loading on the most vulnerable sections of our community.

18. The pricing out of the market of the older age cohorts, if permitted, will put pressure on an already stretched public hospital sector.

19. Minimum benefits should be tailored to synchronise with the chosen community plan benefits. In so far as is possible they should be self adjusting.

20. Irish market is too small to support a large number of insurers because advantages of scale will be lost. Recent history in the banking sector suggests that too many suppliers are actually worse for the consumer than is a small number.