



*Consultation on Risk Equalisation*

**SUBMISSION BY VHI HEALTHCARE  
TO  
HEALTH INSURANCE AUTHORITY**

*August, 2010*

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## SECTION ONE - INTRODUCTION

### Background to the Consultation Process

On the 27<sup>th</sup> of May 2010 the Government announced a set of comprehensive measures to protect older and sicker members of society against the background of a private health insurance market which has become increasingly unstable and is rapidly moving away from the social solidarity of community rating. The Minister for Health and Children articulated the problems in the market place which if not corrected would end community rating

***“I have been concerned that the direction of the market has been moving away from community-rating and the solidarity we want. For example, we’ve seen the creation of a plethora of new policies that are designed for, and marketed to, younger or healthier age groups, or just for the staff of particular corporate customers. I recognise the commercial incentives for this; but we are determined to change those incentives. We want all companies to have an incentive to win and keep older and sicker customers, and to provide better value and developing health insurance services to their customers, particularly in primary and preventive care.”***

The Taoiseach in announcing the decision by the Government to adopt a comprehensive strategy focused on the need to maintain social solidarity stated;

***“We are a society bound together by solidarity. Our values as a people are to support our older people and our sick. This is not just out of a sense of obligation, but because we respect and value older people, and the dignity of each person in their illness, medical condition or disability. We are firm in our view that the principal of solidarity should apply in private health insurance, as well as in public health services. We are insisting that this should have real and practical effect for people. It is in that context that the Government has decided on a comprehensive set of actions to support older and sicker people who have private health insurance.”***

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The Government statement outlined the purpose of the strategy;

***“The Government’s strategy is designed so that***

- ***The cost of health insurance for older and sicker people should be effectively supported by younger and healthier people and should be relatively affordable;***
- ***Individuals do not face premium increases from year to year solely because of their own age or medical history; and***
- ***Insurers compete on a level-playing field for customers in all age groups and can make reasonable profits.”***

The Health Insurance Authority have been asked by the Government to carry out three interrelated tasks. Firstly to review the interim age related tax relief system and to make recommendations to the Minister for Health and Children. Secondly to make recommendations on the form of a new transitional arrangement which would be implemented with effect from the 1<sup>st</sup> of January 2012 and finally to design a new comprehensive risk equalisation scheme. In order to protect older members it will be necessary that the new transitional arrangement will continue pending the complete implementation of a comprehensive new risk equalisation scheme. The likelihood of a legal challenge to a comprehensive risk equalisation scheme appears to be high and therefore Vhi Healthcare believes that the effectiveness of the age related tax relief at source in 2011 and subsequent years will determine whether older members of society are fully protected and effectively supported.

Healthcare costs are primarily determined by an individual's age and their health status. The Health Insurance Authority has previously set out the average risk equalisation healthcare costs from groups of individuals within different age bands. Based on risk equalisation returns an average 18-29 year old will incur healthcare costs that are less than 7% of an average eighty year old.

Age Band	Average risk equalisation healthcare costs 2009
18 – 29	€214
30 – 39	€386
40 – 49	€445
50 – 59	€762
60 – 69	€1,416
70 – 79	€2,376
80 and over	€3,076

**Source: HIA Consultation document**

A community rated market place requires a health insurance company to set the same price for the same insurance contract for all customers irrespective of their age or health status. However due to the significant differences in the average healthcare needs and costs of customers there is a significant financial incentive for a health insurance company to focus its business on providing health insurance to customers under the age of fifty and not to design or market health insurance contracts to customers over the age of sixty as they are significantly loss-making. Under the current levy/age related tax relief system the Health Insurance Authority fully recognises this fact.

***“In a community rated market without a robust risk equalisation system, older and unhealthy customers tend to be extremely unprofitable on average.”***

Under the current levy/TRS system Vhi Healthcare estimates that it will incur losses of €170m in meeting the healthcare needs of its customers over the age of sixty with the average loss increasing as their age increased. Over €132.0m is incurred on customers over the age of seventy.

Age band	2010 average loss per customer	Number of customers	Total losses
60 – 69	€249.0	151,000	€37.6m
70 – 79	€905.40	91,000	€82.4m
80+ over	€1,310	38,000	€49.8m
			€169.8m

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It is the view of Vhi Healthcare that the Government social policy goal of preserving community rating and protecting older members of society can only be achieved if three robust interlocking support mechanisms are put in place. The critical first step in protecting older members of society is that the age related tax relief at source is set at such a level for next year so that older members are no longer loss-making. The necessary three steps are as follows;

Step 1 – A fully effective levy/age related tax relief system for 2011

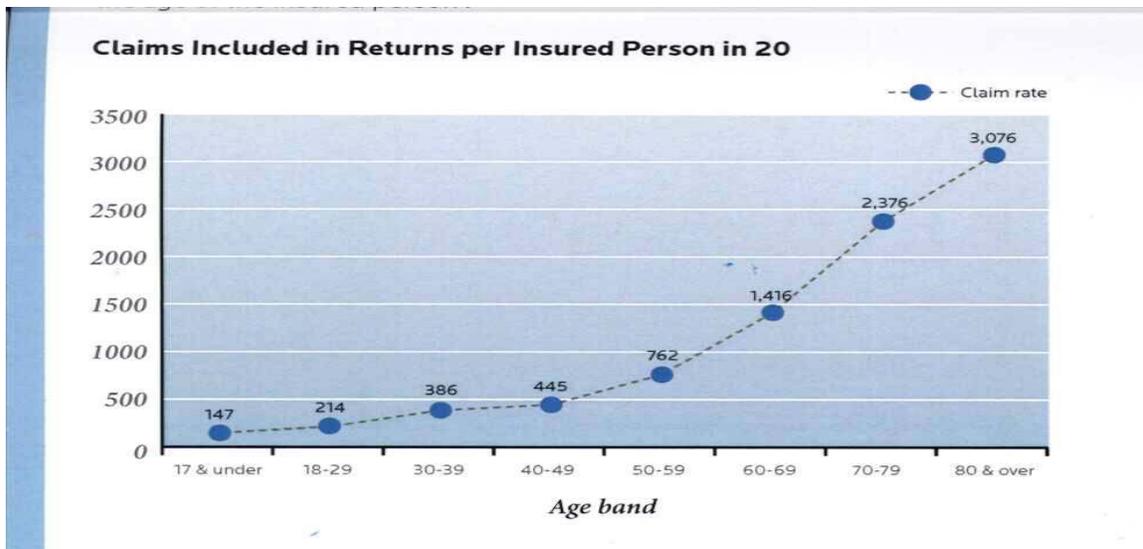
Step 2 – An open ended levy/TRS system for 2012 with a bridging mechanism to a new risk equalisation scheme

Step 3 – New Risk Equalisation Scheme

#### The impact of Competition on Community rating

Since the deregulation of the health insurance market in 1997 both the Government and the Health Insurance Authority have endeavoured to pursue two distinct policy goals' namely sustaining community rating and at the same time encourage the entrance of new health insurance companies into the market place.

Vhi competitors will argue in their submission that they are fully committed to the principles of community rating and social solidarity and that all that is required to protect older health insurance customers is legislation which precludes non community rated health insurance contracts. The following table sets out the average claims costs per the risk equalisation returns.

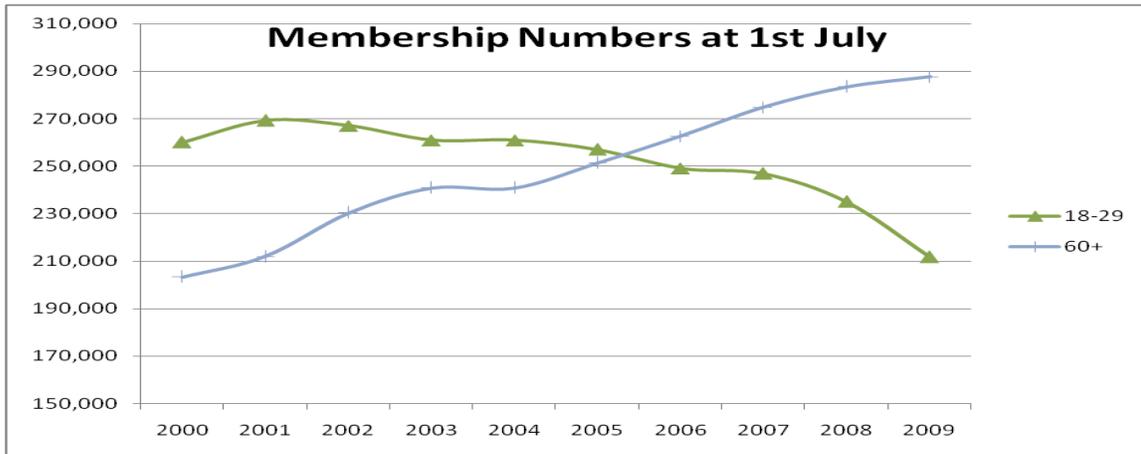


**Based on the RERs returns the average healthcare costs for an 18-29 year old are €214 and €3,076 for an eighty year old.**

It is fully accepted by the Health Insurance Authority that in the absence of a comprehensive mechanism to fully protect older and sicker health insurance customers that the following incentives exist;

1. Insurers will design and market products that are attractive to better risks
2. Insurers with more favourable risk profiles are protected from real competition from insurers with less favourable risk profiles
3. The most profitable insurers will be those that can best use marketing strategies to attract healthy lives and avoid unhealthy lives
4. Insurers with worse risk profiles are obliged to charge higher premiums or incur losses.

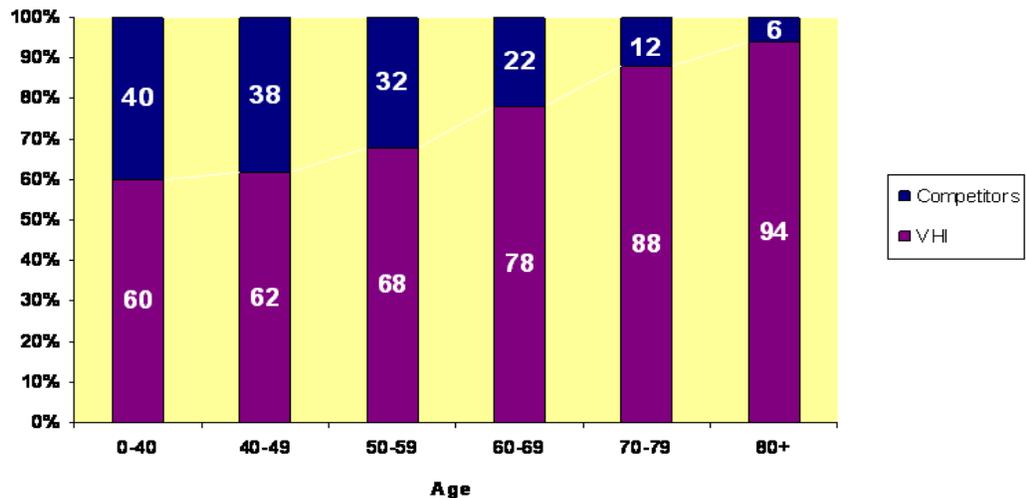
Vhi Healthcare fully agrees with the analysis of the Health Insurance Authority and the following tables demonstrate that the newer entrants have been completely focused on insuring younger members and avoiding insuring older customers.



Vhi estimates that at the end of 31<sup>st</sup> December 2010 that it will have 180,000 customers between the age of 18 – 29 compared to 260,000 in July 2005. All of the new products designed and launched in the last five years have been focused on younger lives as this is the segment of the health insurance market which has the lowest healthcare costs and as previously stated an eighty year old will have fifteen times the healthcare costs of a twenty five year old.

The following table also demonstrates that our new entrant competitors have been successful in insuring the younger age groups but also have been successful in avoiding the older age groups.

### Market Share in Different Age Groups



As a result of differences in the risk profiles between Vhi Healthcare and its competitors the Health Insurance Authority have disclosed the average healthcare costs per the RERs returns of each insurer for 2009.

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<b>Insurer</b>	<b>Average claim cost paid RERs basis</b>
Vhi	€852
Quinn Healthcare	€409
Aviva Healthcare	€386

Whilst the RERs returns do not capture all healthcare costs (they capture circa 80%) these differences in average healthcare costs give Vhi competitors an unbridgeable average healthcare cost advantage in pursuing younger customers.

#### Mechanism to protect older members of society

The only mechanism currently available to the Government and the Health Insurance Authority to protect older members of society is the age related TRS system. The age related tax relief at source was initially designed only to partially compensate those insurers with older members. However this limited scope has resulted in a market place which will no longer protect older members of society and therefore a continuation of it in its current form will not meet any of the Governments primary objectives.

#### Ineffectiveness of Current Age Related Tax Relief System

Vhi Healthcare will receive a net €38m in 2010 from the current levy/age related tax relief system but will actually incur losses of €170m in meeting the healthcare needs of its customers over the age of sixty after taking into account the additional age related tax relief at source.

The purpose of the levy/age related tax relief at source system must be to ensure the continuity of a community rated system which protects older customers. Given that this is the only mechanism currently available to sustain community rating it is necessary to set the age related tax relief at source at a level which ensures that older health insurance customers are no longer loss making and enables all participants in the health insurance market to have the opportunity to compete on equal grounds for all customers and also generate a reasonable return.

In the six month period from the 1<sup>st</sup> January to 30<sup>th</sup> June 2010 Vhi Healthcare has lost €85m in meeting the healthcare needs of its older customers and we anticipate that Vhi Healthcare will incur losses of €170m in meeting the healthcare needs of its older customers in 2010.

<b>Six month period ending 30<sup>th</sup> June 2010</b>				
<b>Age</b>	<b>60 – 69</b>	<b>70 – 79</b>	<b>80+</b>	<b>Total</b>
	<b>€m</b>	<b>€m</b>	<b>€m</b>	<b>€m</b>
Premium Income	105.3	64.8	27.1	197.2
Medical Costs	(141.4)	(136.1)	(68.7)	(346.2)
Admin Costs	(7.9)	(4.8)	(2.0)	(14.7)
Underwriting Loss pre Levy/TRS	(44.0)	(76.1)	(43.6)	(163.7)
Levy/TRS Benefit	25.2	34.9	18.7	78.8
Loss before Investment Income	(18.8)	(41.2)	(24.9)	(84.9)

<b>Age</b>	<b>60 – 69</b>	<b>70 – 79</b>	<b>80+</b>	
Number of Customers	151,000	91,000	38,000	
Average loss per customer for six month period	€124.50	€452.7	€655.0	
Annualised loss per customer	€249.0	€905.4	€1,310	
Annualised loss	€37.6m	€82.4m	€49.8m	€169.8m

Of the €170m which Vhi Healthcare will lose in 2010 in meeting the healthcare needs of its older customers over €130m will have been lost in meeting the healthcare needs of its 129,000 customers who are over the age of seventy. Vhi competitors currently have 12,000 – 13,000 customers over the age of seventy and they are on average both younger and healthier than Vhi customers in the same broad age-group. The current construct of the levy and tax relief system actually means that the oldest members of society generate the greatest losses within the age bands and if community rating is to be sustained this anomaly must be fully addressed and corrected for 2011.

The current levy/TRS system fails to meet any of the Government key objectives and continuation in its current form will ensure that older health insurance customers will pay significantly more than younger health insurance customers for their health insurance.

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- It fails to ensure that the cost of health insurance for older and sicker people should be effectively supported by younger and healthier people. It currently ensures that older people are not effectively supported by younger people.
  - It fails to ensure that individuals do not face price increases due to their age profile. It actually ensures the exact opposite.
  - It fails to ensure that insurers compete on a level playing field for customers in all age groups. Instead it ensures that all competition is focused on younger lives.

#### Need for risk equalisation or equivalent mechanisms

Sophisticated risk equalisation systems or equivalent mechanisms are essential for real and beneficial (i.e. efficient) competition to exist in the health insurance market and to protect older members of society: The obligations created by community rating are such that the health insurance market is not like any other market for goods and services, or for that matter, any other insurance market. Community rating is a public policy intervention by the State, which, left on its own, encourages insurers to compete only for the better risks and discourages insurers from pursuing worse risks. Risk equalisation or equivalent mechanisms are the necessary antidote to this market intervention as it encourages competition across all age groups in the market and ensures that all market participants are incentivised to become more efficient and innovative in terms of cost, product, customer service and provider management. Once introduced, risk equalisation or equivalent mechanisms should encourage a more expansive approach to competition, in particular across all risk groups, by players in the market. Risk equalisation or equivalent mechanisms gives insurers an incentive to compete for the whole market, i.e. all risk groups and to provide value added services for all customers.

#### Likely market developments in the absence of a robust risk equalisation scheme or equivalent mechanisms

The Health Insurance Authority have set out the impact on consumers in the absence of a robust risk equalisation scheme.

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***“Risk selection and segmentation are vital to the commercial success or failure of health insurance providers in a community rated market without a risk equalisation system.”***

Vhi believes that all activities in the market are currently focused on risk selection and segmentation. The consequences for older members are set out by the Health Insurance Authority.

***“The result will be that older and less healthy people will increasingly pay more for their health insurance.”***

Vhi Healthcare believes that the health insurance market has effectively segmented from a product perspective with younger customers primarily insured on newer plans and older customers primarily insured on traditional plans. Vhi Healthcare believes that in order to protect older members of society from the inevitable significant price rises in 2011 it is necessary to address the underlying issues and the starting point must be to significantly increase the age related tax relief at source for older health insurance customers in 2011.

#### Roadmap to a sustainable community rated system

The roadmap to a sustainable community rated system must consist of three inter-related steps if it is to succeed. Firstly the creation of an effective age related tax relief system. Secondly the continuation of the age related tax relief system with a bridging mechanism to a new risk equalisation system and finally the creation of a robust risk equalisation system. Our approach is consistent with the Governments decision of the 27<sup>th</sup> May 2010 where the Taoiseach stated;

***“The Government is convinced that setting out the clear policy direction now and addressing all the inter-related issues together is the best way to give protection to older and sicker people with health insurance.....”***

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## SECTION TWO: THE ROAD-MAP TO A SUSTANIABLE COMMUNITY RATED SYSTEM

To fully protect older members the future road-map have three interrelated steps.

### 1) Step 1 – Increase in age related tax relief for customers over the age of sixty

If community rating is to be sustained in 2011 it will be necessary to significantly increase the current age related tax relief at source levels as under the current age related tax relief at source the greater the age of the customer the greater the level of losses. Consequently if older members of society are to be supported by younger members of society then the group which most needs the age related tax relief should receive the correct amount of support. In particular, there is no real requirement for a fifty to fifty-nine year old receiving €200 of age related tax relief at source as they are not significantly loss-making. Under the current age tax relief at source system Vhi Healthcare will generate the following average losses and total losses on its customers over the age of sixty.

Age	Vhi Average Loss per customer	Customers	Vhi Total Losses
60 – 69	€249.0	151,000	€37.6m
70 – 79	€905.4	91,000	€82.4m
80+	€1,310.0	38,000	€49.8m
			€169.8m

In order to fully protect older members of society it will be necessary to increase the current age related tax relief at source to the level which equates to a community rated age related TRS. At this level customers over the age of sixty will no longer be loss-making.

Age	Current age related TRS 2010	Community rated age related TRS 2011
50 – 59	€200	Nil
60 – 69	€525	€850
70 – 79	€950	€1,925
80+	€1,250	€2,625

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A community age related tax relief at source will have to be funded through a levy on insurance companies. The level of levy increase is very modest in the context of the prize of protecting older health insurance customers.

	<b>Current levy</b>	<b>Required increase</b>	<b>Revised levy</b>
Child	€55.00	€26	€81.0
Adult	€185.0	€88	€273.0

The benefits of a community rated age related TRS funded by a levy is clear when measured against the Government key objectives:

**Objective 1** – The cost of health insurance for older people is effectively supported by younger people

**Objective 2** – Individuals will not face price increases from year to year solely because of their own age

**Objective 3** – Insurers compete on a level playing field for all customers and all can make reasonable and sustainable profits.

Under this approach customers over the age of sixty will no longer be loss-making and will be as attractive to insure as customers under the age of sixty. This will incentivise insurers to develop products and services which enhance older people's healthcare outcomes particularly in areas such as chronic disease management programmes and non hospital based services in a community setting such as hospital in the home.

## **2. Step 2 – Open ended levy/TRS system with a bridging mechanism to a Risk Equalisation system.**

Vhi Healthcare believes that an open-ended levy/age related tax relief system will have to be implemented and legislated for from 2012 onwards in order to ensure that older members continue to be protected. The open ended levy/TRS system will have to continue until a risk equalisation scheme has been fully implemented with transfers having taken place. It will not be sufficient for the transitional arrangement to cease when the new risk equalisation legislation is enacted as it is likely that a new risk equalisation scheme will be legally challenged. There will be some legal complexity in having an open ended levy/TRS system and a risk equalisation scheme running in parallel and a mechanism will need to be found

which bridges the transitional arrangement and potential transfers under a risk equalisation scheme. The following approach can facilitate the transition from a levy/TRS system to a risk equalisation system:

1. The open ended transitional arrangement continues with the following community rated age tax relief at source and the necessary levy to fund the protection of older members.

<b>Age related TRS</b>		<b>Levy</b>	
50 – 59	Nil	Child	81.0
60 – 69	€850	Adult	273.0
70 – 79	€1,125		
80+	€2625		

2. This system continues until actual transfers actually occur under a new risk equalisation scheme. If transfers never occur the levy/TRS system will continue.
3. A bridging mechanism with a offset arrangement is established on the creation of a new risk equalisation scheme whereby the amounts received or paid under the levy/TRS mechanism are offset against the amounts receivable/payable under the risk equalisation scheme.
4. A simple example illustrates the concept

<b>Insurer</b>	<b>Receivable / (payable) under risk equalisation</b>	<b>(Net receipts)/ payments under levy/TRS</b>	<b>Balancing amount</b>
A	€120.0m	(€105.0m)	€15.0m
B	(€60.0m)	€50.0m	(€10.0m)
C	(€60.0m)	€55.0m	(€5.0m)

5. If there are no amounts transferred under risk equalisation scheme due to a successful legal challenge then the offset mechanism falls away and the levy/age related TRS system continues.

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6. Vhi Healthcare believes the exact bridging and offset mechanisms should be legislated under the Risk Equalisation legislation and the revised levy/age related TRS system should be open-ended and continue until a new risk equalisation scheme is established and transfers have occurred. This will be necessary to give all the current and potential market participants the necessary certainty and clarity in relation to the community rating regulatory framework, particularly in relation to the mechanism which will protect older members.

7. Section 3 deals with our proposed risk equalisation system.

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## SECTION THREE: TECHNICAL PROPOSAL ON RISK EQUALISATION

### 1. Underlying Principles

It is the view of Vhi Healthcare that to develop a robust risk equalisation system there is a need to use age, gender and health status as risk factors. Health status is used in all countries that have a robust risk equalisation in place including the Netherlands and Germany. In this context, it is clear that in the last three years, the observed differences in the risk profiles between insurers have significantly increased indicating the critical importance of strengthening the wholly ineffective age based system that currently applies.

The choice of proxy to allow for health status is problematic given the difficulties in measuring differences in health status between insured persons and the complexity of introducing such a system.

The use of a diagnostic approach while it has many advantages is complicated by the need to have the same coding systems for all insurers, the relative scarcity of data in certain diagnostic groups and the need for expert knowledge to support its introduction. Furthermore, such an approach needs to be calculated for each age and gender cell. There are also potential difficulties in terms of drafting the relevant legislation.

A resource intensity approach is easier to implement and has been adopted in many countries as a reasonable proxy for health status (e.g. most recently Switzerland has been working to use such an approach). While a length of stay proxy for health status could be used it does not allow for the fact that many complex medical treatments are provided on a day patient basis or in a non-hospital setting (e.g. chemotherapy and radiotherapy services). As an alternative, a cost-based health status proxy could be used that allows for these types of services.

It is for these reasons that we propose the following two-part system of risk equalisation based upon a resource intensity approach using the cost of services as a relevant proxy for health status.

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We propose, for the first part, the use of an age and gender retrospection risk equalisation pool for members who having relevant expenditures less than a defined threshold in a given year. This would include primary care services that are relatively cheap to provide together with the cost of services for the majority of hospital based treatments. Primary care services are increasingly being used as part of the treatment cycle for patients and are consequently becoming a higher proportion of benefits for insurers. Furthermore, it is a matter of Government policy that primary care should be the cornerstone of the health system<sup>1</sup>.

The second part would be a high risk pool for members who have expenditures equal to or in excess of this threshold in a given year. Such high risk pools operate are a feature of the risk equalisation system that operates in many countries including in Australia and the Netherlands.

We outline below some of the other technical aspects of such a system.

## **2. Technical aspects**

### **Appropriate threshold**

We believe the appropriate threshold cut-off between the age and gender risk equalisation pool and the high risk pool is €10,000 per annum. This threshold is such that it is equivalent to insured persons having a very serious medical condition. For example, a member receiving more than ten nights treatment in a private bed in a public hospital, due to significant underlying chronic conditions such as chronic heart failure having a severe mental illness necessitating more than twenty nights in a private psychiatric hospital or receiving significant cancer, cardiac or orthopaedic treatments.

The choice of this threshold ensures that only complex treatments for individuals with chronic underlying health issues are included in the high risk pool while, yet, meaning the system goes beyond using just age and gender on a risk factors for the purposes of the risk equalisation system. The current distribution of claims size by member would mean a higher threshold than €10,000 would significantly reduce the effectiveness of the system in sharing risk beyond age and gender.

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<sup>1</sup> See “Primary Care – A New Direction”, Department of Health and Children (2001)

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It should be noted that approximately 1.6% of our members accessed healthcare services with costs in excess of €10,000 in 2008 which is reasonably small proportion of our membership. The threshold should be increased each year in line with cost increases.

All benefit for members who have had claims paid of €10,000 or more would get included in the high-risk pool while benefit paid for members who had claims less than €10,000 would be included in the age and gender pool. Thus, for example, if a member had benefit paid of €15,000 the full €15,000 would get included in the high-risk pool.

### **Part 1: *The risk equalisation pool by age and gender***

#### **Method of calculation**

In broad terms, the calculation of the transfers between insurers under this part of the system would follow that under the risk equalisation system set out under the 2003 Risk Equalisation regulations.

A full outline of how this system would work is provided in appendix 1.

#### **Own cost or market cost**

Using an insurer's own cost within each risk cell can lead to unquantifiable differences in risk between insurers within that cell not being equalised. However, this problem is removed if a suitably robust method of risk equalisation is used that means such variations in risk are removed. Under our proposal, we believe that this is the case.

On this assumption we would be comfortable for transfers to be based upon the own costs of each insurer within each age and gender category under the part 1 of our proposal. However, where there is not credible data within each risk cell (age band and gender category) the market average cost should be used as currently happens with appropriate credibility criteria similar to that currently used being adopted.

#### **Self-financing**

The formula under part 1 should be self-financing with the mechanism for ensuring contributions to and from the risk equalisation fund being equal under part 1 being identical to that that currently applies. This approach favours contributing insurers,

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rather than recipient insurers, in that any differences in risk profile arising from factors other than age and gender or arising because of membership mixes are not allowed for within the formula.<sup>2</sup>

## **Part 2: *The high risk pool***

### **Manner of operation**

All insurers would report the total value of claims exceeding the defined threshold of €10,000 each year to the HIA together with their membership. Following reporting, the experience of all insurers would be combined and payments would be made to or from each insurer based upon the aggregate difference between its own total claims costs and the expected total claims cost for high cost members.

### **Own cost or market cost**

Under the high risk pool the market average claims cost per person would be compared with the insurer's own average claims cost per person and any differences would be allocated to the insurer.

### **Self-financing**

Under the high risk pool this part would be automatically self-financing given the nature of the calculation assuming that the actual membership is used rather than the equivalent adult lives approach used in part 1.

### **Other issues**

#### **Benefits to be Included**

Under both parts, all claims should be included in the system based upon medical necessity. This would mean most claims paid within the market should be included as they constitute medically necessary treatment.

#### **Disease Management and Wellness Programmes**

We also believe that insurers should be incentivised to provide disease management programmes and promote wellness among their insurer customers. In this regard, we believe that such expenditure should be eligible for the purposes of equalisation.

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<sup>2</sup> Many possible approaches could be used for ensuring the system is self-financing and they all have their own advantages and disadvantages.

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We accept that it is sometimes difficult to categorise some expenditure as being disease management or wellness related so an appropriate definition would need to be outlined for such expenditures.

### **Prospective or Retrospective Nature**

The chosen system could be prospective or retrospective in nature but, on balance, we favour a retrospective system as it would involve less theoretical debate on assumptions etc and is capable of independent verification by third-parties.

### **Appropriate age bands**

The current 10-year age bands do not allow sufficiently for heterogeneity in claims experience within the age band. We thus propose that age should be based upon five-year age bands in general with 0-9 and 10-17 for children. Thus the following age bands should be used: 0-9, 10-17, 18-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85 and over.

In Appendix 2, we demonstrate using Vhi Healthcare internal data that there is a surprising degree of variation in claims experience within each current ten year age band. It is most pronounced within the 60-69 and 70-79 year old age bands where the required use of medical care increases significantly at an individual person level.

### **Calculation of appropriate membership**

While other method may be more accurate the exposed membership used for the purposes of the calculation for each insurer, should be calculated as the simple average membership across the period.

### **Method of submission of returns and transfers**

If using a retrospective approach the same arrangements as under the previous system should apply for the risk equalisation element namely:

1. Insurers make returns to the Health Insurance Authority
2. Required contributions are calculated
3. Contributions to/from insurers are made.

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## **SECTION FOUR: RESPONSES TO CONSULTATION**

*Responses have been numbered as per the consultation paper.*

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

Risk factors should be sufficient to explain any underlying differences in risk profiles between insurers and meet the principal objective of risk equalisation in ensuring risk solidarity within the market. The experience of the many countries that have adopted risk equalisation should be used as guide to determining the risk factors to be used. Notwithstanding this, all risk factors should be corroborated by evidence from the market. There is also the issue of practicality to ensure, for each risk factor chosen, that there is sufficient credible data for each risk cell.

### **Q4.2 What underlying risk factors should be used?**

Age, gender and a health status measure should be used in keeping with what happens in most other countries that have a risk equalisation system in place.

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

Membership profiles and claims experience should be collected from all insurers split by each of the risk factors. If our proposed risk equalisation framework was adopted then there would be no need to collect any other data.

Age should be defined using the following age bands: 0-9, 10-17, 18-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84 and 85 years and over.

### **Q4.4 Should underlying risk factors be fully or partially equalised?**

All risk factors should be fully equalised, as they by definition they explain variations in risk and are therefore are required to ensure the effectiveness of the mechanism.

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***Q4.5 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?***

The integrity of the regulatory system is dependent upon having accurate and consistent returns from and between insurers. The generation of the returns is a very complex process. All returns should be audited but, in addition, the Health Insurance Authority should have on-site visits to insurers to ensure the integrity of the returns.

As required, the Authority should be given new powers to work with insurers to interpret and investigate issues surround the consistency of returns.

***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?***

As indicated above the HIA should actively participate in validating returns and should be given powers to interpret returns.

***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?***

In addition, risk equalisation other regulatory measures are necessary to support community rating including lifetime cover and minimum benefits.

***Q4.8 What are your views on using diagnosis related risk factors in a risk equalisation scheme?***

Diagnostic related risk factors are ideally the system that should be used to identify differences in risk profile between insurers. However, the use of such a system is extremely complicated and would difficult to implement. One of the issues surrounding the use of such as system is that it would necessitate all insurers coding all claims in precisely the same manner using the same version of ICD codes (i.e. International Classification of Diseases system) and the same version of the diagnostic related grouper software (DRG-grouper).

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Even if it were possible to get all insurers to implement the same system in a short period of time the number of diagnostic related groups are so large that it would be impractical to implement. For example, under the system of DRG-coding that we use there are approximately 1,000 some of which would need to be considered separately by whether the member had an ambulatory claim or an inpatient claim. Furthermore, these codes would need to be analysed by age and gender cell to carry out a meaningful risk equalisation calculation. We do not believe such credible data is available in the market to facilitate the introduction of such a system.

***Q4.9 What diagnosis related factors should be used?***

We do not favour the use of a diagnosis approach for the reasons outlined above.

***Q4.10 What data should be collected from undertakings in respect of diagnosis related factors?***

If it were to be used data on the cost of claims by each diagnosis category (i.e. DRG level if it is being used) for each age and gender cell should be collected. In addition, the corresponding number of insured persons by age and gender cell should be collected.

***Q4.11 What are your views on the difficulties in collecting and auditing data and how can these issues best be tackled?***

One of the biggest challenges is to collect consistent data between insurers. This arises from the very technical nature of risk equalisation. To ensure consistency the Authority should have powers to investigate and interpret data as required. Allied to this we strongly advocate that the auditing profession under the auspices of the appropriate professional body work with the Authority and insurers to get a consensus approach on the matters relating to the submission of returns.

***Q4.12 Do issues arise for private and public hospitals?***

All treatments regardless of the settings in which the treatment is provided should be treated in a consistent way within the risk equalisation system.

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**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?***

To ensure confidence there needs to be a very detailed review of the returns of all insurers involving, for example, on site reviews as required. Furthermore, certain matters of interpretation should be discussed directly with insurers. The cost of establishing such confidence will be relatively small in comparison to the likely transfers under the system. The cost of ensuring integrity the system can be funded out of the existing reserves of the Authority.

**Q4.14 *Should the differences in costs between different diagnosis risk factors be fully or partially equalised?***

All differences in costs should be equalised within the market as any such differences are risk related.

**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?***

As we indicated above while the diagnosis based approach has advantages it would be complex to implement and therefore we do not advocate at present.

**Q4.16 *Should insurers provide the data at a DRG level or at a DRG Category level?***

Notwithstanding our comments above if such an approach is to be used the data should be collected at DRG level and then aggregated as appropriate based upon clinical advice on the appropriateness of the grouping. We would believe that this is a very complex task and will require a large range of medical and non-medical skills to design and review.

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**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?***

Notwithstanding our comments about the difficulty of introducing such a system, ambulatory treatment or treatment provided in a non-hospital setting that is medically necessary should be included in the system. If it is not possible to code such treatments at DRG level such claims should be coded in separately category and should the equalisation mechanism should be applied in the same manner as for other categories that are DRG based.

**Q4.18 *What are your views on using resource usage related risk factors in a risk equalisation scheme?***

Given the difficulties in adopting the diagnostic related groups approach we believe that the resource usage is the better one approach to use.

**Q4.19 *What resource usage factors should be used?***

We suggest the use of a high-risk cost pool as being the best way to apply this system. Such a high-risk pool is used in a number of countries that have a risk equalisation system in place including in the Netherlands.

**Q4.20 *What data should be collected from undertakings in respect of resource usage factors?***

Eligible costs above and below the threshold should be recorded for each member and a summary return should be submitted of the split by age and gender cell.

**Q4.21 *Should the differences in costs between different resource usage risk factors be fully or partially equalised?***

They should be fully equalised as any differences are as a result of risk differences between insurers.

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**Q4.22 *Would a risk equalisation system based on resource usage related risk factors be sufficiently effective in supporting community rating?***

We believe the system as we have outlined would meet this objective. We propose a threshold of €10,000. If a higher threshold was used it would severely compromise the effectiveness of the system and it would merely be a age and gender pool that would be ineffective.

**Q4.23 *This consultation paper has suggested some possible measures of health status age and gender. Are there other measures that might be adopted?***

We suggest our high-risk pool together with the age and gender pool below the threshold.

**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?***

Notwithstanding our proposal, if a risk approach was to be adopted then multiple risk factors should be used to allow for health status as any one factor would be ineffective as identifying differences in risk profile arising from risk status. Other countries use multiple risk factors for health status precisely for this reason.

**Q5.1 *To what extent should costs incurred in providing primary care, preventative treatment / care and care in the community be included in the system?***

Such costs should be included in so far as they are medically necessary treatments or because the related to expenditures on items that encourage more healthy lifestyles (e.g. wellness and screening services).

**Q5.2 *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?***

The principle should be that under risk equalisation all identical treatments should be included in the mechanism regardless of the setting in which the benefits are

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provided. At present the type and cost of providing for example cancer treatment is no different in each hospital and therefore the element of cost that is luxury in nature is very small. We therefore do not believe that luxury characterisation is meaningful. We believe therefore that all benefit should be included in the equalisation mechanism.

***Q5.3 Should fixed price procedures be subject to different limits than other forms of treatment? How should fixed price procedures be defined?***

The principle under risk equalisation should be that all identical treatments should be included in the mechanism in the same way regardless of the setting in which the treatment is provided or the method of reimbursement the insurer uses to pay the medical provider. Under this principle, the issue of fixed price procedures and how they should be defined becomes irrelevant.

***Q6.1 What are the views of stakeholders in relation to this approach?***

We believe that the age related approach is appropriate for the transitional system as described above.

***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?***

While in theory this approach could be used for considering differences in health status we believe it is not the best way of doing this and a separate data collection process should be arranged for this purpose.

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

While it could be done we do not propose it given the complexities involved in using a prospective system for health status.

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

The system should not encourage risk selection be it implicit or explicit by insurers. We do not support arrangements that convey an advantage to new entrants as it would encourage new entrants to engage in risk selection and therefore destabilise community rating.

***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?***

While theoretically this might be an issue in practice this is not likely to be an issue given the likely numbers of members having loadings. We therefore do not believe it should be taken account of until it becomes material.

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

The approach used should be consistent with the minimum benefit regulations.

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

Yes, in the interests of openness and transparency all data should be published.

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## APPENDIX 1: OUTLINE OF PROPOSED SYSTEM

*For illustrative purposes only*

### **Assumptions:**

1. Two insurers of different size
2. Different cost profile in each age cell (cost per person and relative size)
3. We ignore gender for the purposes of this calculation

### **Base data - Membership**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	121,000	57,000	178,000
10-17	103,000	9,000	112,000
18-24	81,000	45,000	126,000
25-29	68,000	50,000	118,000
30-34	70,000	40,000	110,000
35-39	65,000	35,000	100,000
40-44	70,000	29,000	99,000
45-49	72,000	26,000	98,000
50-54	69,000	23,000	92,000
55-59	66,000	16,000	82,000
60-64	61,000	8,000	69,000
65-69	47,000	6,000	53,000
70-74	40,000	3,000	43,000
75-79	30,000	1,500	31,500
80-84	21,000	1,000	22,000
85+	16,000	500	16,500
<b>Overall</b>	<b>1,000,000</b>	<b>350,000</b>	<b>1,350,000</b>

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**Base data – Total claims**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	€22,990,000	€9,690,000	€32,680,000
10-17	€12,875,000	€1,080,000	€13,955,000
18-24	€19,035,000	€9,450,000	€28,485,000
25-29	€19,720,000	€12,000,000	€31,720,000
30-34	€30,800,000	€16,000,000	€46,800,000
35-39	€32,500,000	€16,450,000	€48,950,000
40-44	€37,450,000	€14,500,000	€51,950,000
45-49	€40,680,000	€14,430,000	€55,110,000
50-54	€54,165,000	€17,020,000	€71,185,000
55-59	€66,000,000	€14,400,000	€80,400,000
60-64	€85,400,000	€9,600,000	€95,000,000
65-69	€86,950,000	€9,600,000	€96,550,000
70-74	€92,000,000	€6,300,000	€98,300,000
75-79	€87,000,000	€3,900,000	€90,900,000
80-84	€63,000,000	€2,800,000	€65,800,000
85+	€44,800,000	€1,200,000	€46,000,000
<b>Overall</b>	<b>€795,365,000</b>	<b>€158,420,000</b>	<b>€953,785,000</b>

**Base data – Claims for membership below €10,000 threshold**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	€17,545,000	€7,695,000	€25,240,000
10-17	€9,373,000	€765,000	€10,138,000
18-24	€13,446,000	€7,200,000	€20,646,000
25-29	€14,620,000	€9,000,000	€23,620,000
30-34	€24,150,000	€12,400,000	€36,550,000
35-39	€23,725,000	€11,200,000	€34,925,000
40-44	€21,700,000	€7,540,000	€29,240,000
45-49	€23,760,000	€7,800,000	€31,560,000
50-54	€27,600,000	€8,510,000	€36,110,000
55-59	€31,020,000	€6,400,000	€37,420,000
60-64	€34,465,000	€4,400,000	€38,865,000
65-69	€47,000,000	€5,400,000	€52,400,000
70-74	€60,000,000	€4,200,000	€64,200,000
75-79	€42,000,000	€1,800,000	€43,800,000
80-84	€42,000,000	€1,700,000	€43,700,000
85+	€32,000,000	€1,100,000	€33,100,000
<b>Overall</b>	<b>€464,404,000</b>	<b>€97,110,000</b>	<b>€561,514,000</b>

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**Base data – Claims for membership above €10,000 threshold**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	€5,445,000	€1,995,000	€7,440,000
10-17	€3,502,000	€315,000	€3,817,000
18-24	€5,589,000	€2,250,000	€7,839,000
25-29	€5,100,000	€3,000,000	€8,100,000
30-34	€6,650,000	€3,600,000	€10,250,000
35-39	€8,775,000	€5,250,000	€14,025,000
40-44	€15,750,000	€6,960,000	€22,710,000
45-49	€16,920,000	€6,630,000	€23,550,000
50-54	€26,565,000	€8,510,000	€35,075,000
55-59	€34,980,000	€8,000,000	€42,980,000
60-64	€50,935,000	€5,200,000	€56,135,000
65-69	€39,950,000	€4,200,000	€44,150,000
70-74	€32,000,000	€2,100,000	€34,100,000
75-79	€45,000,000	€2,100,000	€47,100,000
80-84	€21,000,000	€1,100,000	€22,100,000
85+	€12,800,000	€100,000	€12,900,000
<b>Overall</b>	<b>€330,961,000</b>	<b>€61,310,000</b>	<b>€392,271,000</b>

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**Part 1: Age and gender risk pool**

**Membership proportions**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	12.1%	16.3%	13.2%
10-17	10.3%	2.6%	8.3%
18-24	8.1%	12.9%	9.3%
25-29	6.8%	14.3%	8.7%
30-34	7.0%	11.4%	8.1%
35-39	6.5%	10.0%	7.4%
40-44	7.0%	8.3%	7.3%
45-49	7.2%	7.4%	7.3%
50-54	6.9%	6.6%	6.8%
55-59	6.6%	4.6%	6.1%
60-64	6.1%	2.3%	5.1%
65-69	4.7%	1.7%	3.9%
70-74	4.0%	0.9%	3.2%
75-79	3.0%	0.4%	2.3%
80-84	2.1%	0.3%	1.6%
85+	1.6%	0.1%	1.2%
<b>Overall</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Expected membership**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	131,852	46,148	178,000
10-17	82,963	29,037	112,000
18-24	93,333	32,667	126,000
25-29	87,407	30,593	118,000
30-34	81,481	28,519	110,000
35-39	74,074	25,926	100,000
40-44	73,333	25,667	99,000
45-49	72,593	25,407	98,000
50-54	68,148	23,852	92,000
55-59	60,741	21,259	82,000
60-64	51,111	17,889	69,000
65-69	39,259	13,741	53,000
70-74	31,852	11,148	43,000
75-79	23,333	8,167	31,500
80-84	16,296	5,704	22,000
85+	12,222	4,278	16,500
<b>Overall</b>	<b>1,000,000</b>	<b>350,000</b>	<b>1,350,000</b>

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**Standardised claims with own average costs and expected membership**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	€19,118,519	€6,230,000	€25,348,519
10-17	€7,549,630	€2,468,148	€10,017,778
18-24	€15,493,333	€5,226,667	€20,720,000
25-29	€18,792,593	€5,506,667	€24,299,259
30-34	€28,111,111	€8,840,741	€36,951,852
35-39	€27,037,037	€8,296,296	€35,333,333
40-44	€22,733,333	€6,673,333	€29,406,667
45-49	€23,955,556	€7,622,222	€31,577,778
50-54	€27,259,259	€8,825,185	€36,084,444
55-59	€28,548,148	€8,503,704	€37,051,852
60-64	€28,877,778	€9,838,889	€38,716,667
65-69	€39,259,259	€12,366,667	€51,625,926
70-74	€47,777,778	€15,607,407	€63,385,185
75-79	€32,666,667	€9,800,000	€42,466,667
80-84	€32,592,593	€9,696,296	€42,288,889
85+	€24,444,444	€9,411,111	€33,855,556
<b>Overall</b>	<b>€424,217,037</b>	<b>€134,913,333</b>	<b>€559,130,370</b>

**Summary calculations**

<b>Insurer</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
Equivalent adult lives	850,667	306,000	1,156,667
Equivalent adult proportion	85.1%	87.4%	85.7%
UEAP / MEAP	99.3%	102.0%	100.0%
Cell standardised first stage	€424,217,037	€134,913,333	
Cell standardised second stage	€421,185,169	€137,668,254	
Transfer to fund	-€40,558,254	€40,558,254	

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## **Part 2: High cost risk pool**

### **Relevant claims**

<b>Age band</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
0-9	€5,445,000	€1,995,000	€7,440,000
10-17	€3,502,000	€315,000	€3,817,000
18-24	€5,589,000	€2,250,000	€7,839,000
25-29	€5,100,000	€3,000,000	€8,100,000
30-34	€6,650,000	€3,600,000	€10,250,000
35-39	€8,775,000	€5,250,000	€14,025,000
40-44	€15,750,000	€6,960,000	€22,710,000
45-49	€16,920,000	€6,630,000	€23,550,000
50-54	€26,565,000	€8,510,000	€35,075,000
55-59	€34,980,000	€8,000,000	€42,980,000
60-64	€50,935,000	€5,200,000	€56,135,000
65-69	€39,950,000	€4,200,000	€44,150,000
70-74	€32,000,000	€2,100,000	€34,100,000
75-79	€45,000,000	€2,100,000	€47,100,000
80-84	€21,000,000	€1,100,000	€22,100,000
85+	€12,800,000	€100,000	€12,900,000
<b>Overall</b>	<b>€330,961,000</b>	<b>€61,310,000</b>	<b>€392,271,000</b>

### **Relevant membership**

#### **Calculations – High Risk pool**

<b>Insurer</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
Membership	1,000,000	350,000	1,350,000
Cost per person	€331	€175	€291
Standardised cost	€290,571,111	€101,699,889	€392,271,000
Contribution to high cost pool	-€40,389,889	€40,389,889	€0

#### **Total transfer**

<b>Insurer</b>	<b>Insurer A</b>	<b>Insurer B</b>	<b>Market</b>
Age gender pool	-€40,558,254	€40,558,254	€0
High risk pool	-€40,389,889	€40,389,889	€0
Total	-€80,948,142	€80,948,142	€0

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## APPENDIX 2: HOW COSTS VARY BY 5-YEAR AGE BANDS COMPARED TO 10-YEAR AGE BANDS

Age band	Percentage of 10-year age band level
0-9	113%
10-17	83%
18-24	90%
25-29	111%
30-34	93%
35-39	107%
40-44	91%
45-49	109%
50-54	86%
55-59	115%
60-64	87%
65-69	117%
70-74	91%
75-79	113%
80-84	103%
85+	94%

Source: Vhi Healthcare, Internal data

### Explanation

\*\* From this we see that within the 60-69 age band, the average cost per member is 87% of the 60-69 average cost per member for the 60-64 year old age band. Correspondingly, the average cost per member is 117% of the 60-69 average cost per member for the 65-69 age band. This demonstrates how having 5-year age bands leads to more homogenous age groups.