The Role of Minimum Benefits within Private Health Insurance

A Vhi Healthcare submission to the Health Insurance Authority

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1 Introduction

1.1 Background

One of the fundamental principles on which Irish private medical insurance is based is that there is equity of access to cover for everyone regardless of their risk profile. This principle has underpinned the system for almost fifty years. Until the mid-1990s the principle was not explicitly laid out until the Health Insurance Act (1994) was enacted together with a series of supporting statutory regulations in 1996.

Community rating and risk equalisation, open enrolment and lifetime cover are all part of the regulatory structure designed to support this concept. Regulations to prescribe a minimum set of benefits that all insurers must provide are important to ensure that insurers will not seek to circumvent community rating through product design.

However, since the publication of the 1996 minimum benefit regulations they have not been updated to take account of underlying increases in medical costs or new technology. Against this backdrop the Health Insurance Authority (HIA) have now initiated a consultation process to review the need for changes in the minimum benefits that operate within the market.

1.2 Overview of document

This document represents the Vhi Healthcare submission to the HIA. It is organised as follows:

- Section 2 considers issues affecting consumers that are directly related to minimum benefits;
- Section 3 suggests the process under which minimum benefits should be updated at regular intervals; and
- Section 4 provides a summary of Vhi Healthcare recommendations in regard to minimum benefits.

2 Minimum benefits and the consumer

2.1 Importance of minimum benefits

One of the key requirements of the consumer interest is equity between all consumers regardless of where they purchase their private medical insurance. This means that all consumers should not only share equally in the cost of healthcare but also have a reasonable level of access to all benefits and services regardless of their underlying risk characteristics.

Without such regulations a less than benevolent insurer could select preferred risks based upon removing access to certain benefits that are more attractive to higher risks, e.g. sick and elderly. Such behaviour could limit the attraction of their product to segments of the market. A particular example of such a benefit is in relation to surgical procedures to cover the complete replacement of the hip joint. The likelihood of younger people needing this benefit is low. Therefore, removing access to this benefit on a particular insurer's products would not be a significant deterrent from choosing that insurer for younger people but would discourage older people from choosing that insurer.

To date it is worth noting that all insurers in the market provide benefits considerably in excess of the minimum benefit levels. However, this does not negate the importance of minimum benefits and the practice in Australia provides an example of the potential exposure once regulations in this area are relaxed.

2.2 Effects of geographical location on minimum benefits

Access to a prescribed minimum set of benefits not only relates to the treatment being covered by an insurer but must also include to there being a realistic prospect that the treatment is available to all consumers within a reasonable distance of their place of residence. Geographic location has not been a criterion that has been used to establish minimum benefits in Ireland. Arguably, given the relatively small size of the country this

is appropriate and the definition of a reasonable distance is somewhat subjective. However, we believe that there is a certain rationale for minimum benefits being constructed in such a way so as to discourage a less than benevolent insurer from only providing benefits for certain treatments in locations a considerable distance from their market. An extreme example best illustrates this point.

Under current minimum benefit regulations an insurer who predominantly has a membership in Dublin could provide coverage for hip replacements only in the most northerly point in Donegal thereby discouraging older people from purchasing their product.

On the other hand minimum benefit requirements should not be used to require insurers to cover all individual providers. Some reasonable geographic requirement should be included but it should be noted that some treatments may only be performed efficiently and effectively in certain settings.

2.3 Role of claims excesses

We have consistently outlined the potential destabilising effects that high claim excesses can have on the market. Not only do they reduce the level of indemnification within the market (which could be justifiable on cost containment grounds) but they encourage market segmentation and their affect is to effectively allow some insurers to gain a better risk profile.

With high excesses, such excess products are less attractive than non-excess products for high-risk groups. This is because the resulting reduction in premium, as a consequence of the excess, is less than the annualised value of the excess for the sick (who incur the excess each time they claim) under such products. Such a situation not only allows insurers to use excess products to choose preferred risks it also discriminates between high-risk and low-risk consumers which goes against the principle that underpins the insurance system in Ireland.

Recommendation

We therefore recommend that a strict cap be place on excess product within the minimum benefits regulations, i.e. a defined monetary cap (e.g. €100 per claim) or a claims' excess related to the premium (e.g. no more than 10% of premium).

2.4 Ancillary health benefits

We do not consider that ancillary health benefits, such as primary care products, should be part of the minimum benefits. This is based upon the nature of these benefits and their relative size.

3 Setting Minimum Benefits

3.1 Bases for choice of minimum benefits

A number of potential options exist for setting minimum benefit levels. These include the following:

- ***Option 1: - Clinical basis*** under which all insurers must provide benefits that are medically necessary. Under this basis clinicians would determine the basic package of benefits that all insurers must provide. For example, diabetes, asthma, coronary heart disease, hypertension would need to be covered to a prescribed level;
- ***Option 2 - Benefit treatment basis*** under which minimum benefits are defined not from a clinical perspective but from an insurance perspective with accompanying lists of benefits and level of coverage; and
- ***Option 3 - Facility basis*** under which minimum benefits are defined by reference to the type of facility (not individual facilities) in which the patient is treated rather than the underlying treatment.

The methods used to define minimum benefits vary considerably between countries. In social insurance systems where full indemnity is more of an issue the clinical approach is most often used; while in countries where a voluntary insurance approach exists (even with a social insurance system) either options 2, 3 or a combination thereof are used. This is sensible given that insurance by its nature has a series of treatments that are listed and beneficiaries are either covered up to a defined level or not covered at all for these treatments.

The current basis in Ireland is a mixture of Options 2 and 3 under which separate schedules are provided in the Regulations listing the prescribed minimum benefits

applicable by facility and the insured procedures provided within the market at the time of publication of the Regulations in 1996.

We do not consider it practical or consistent with the nature of the Irish health system (where voluntary insurance applies) to operate a clinical approach.

Recommendation:

Vhi Healthcare therefore recommends that the basis for the setting of minimum benefits should to be related to a benefit or a facility type approach where insurers must provide defined benefits to a defined level.

3.2 Criteria for choice of minimum benefits

Given these possible approaches the levels of minimum benefits that must be provided by insurers needs to be established. A number of criteria are relevant in choosing the appropriate level of benefits:

- They need to be **meaningful** to protect consumers and ensure market stability. For example, providing €1 of benefit for a procedure that costs €20,000 does not give the member a sufficient level of minimum coverage.
- They **should not discourage cost efficiency or promote inefficiencies**. For example, minimum benefits should not be constructed in such a way as to discourage the use of more efficient settings or methods of reimbursement;
- They need to be **practical and simple to implement** and not unduly cumbersome on existing insurers or potential new entrants to the market.
- They should be **current and be able to be updated regularly** to meet changes in the market from, for example, inflation or new technologies.
- They should be **reasonable** from the overall perspective of the consumer. In this regard, we would cite the example of geographic reasonableness. An insurer should not be able to attempt to get around the prescribed minimum benefit

regulations by placing other unreasonable conditions on the provision of that benefit, e.g. limited geographic cover.

Recommendation

Given these criteria Vhi Healthcare recommends that minimum benefits be structured in a similar manner to the current system but that there be regular reviews to update them for new procedures, type of facilities and relevant changes in the reimbursement mechanisms to providers. This includes defined monetary limits being set based upon an appropriate market-related benchmark, e.g. 80% of the cost of provision of the service.

3.3 Update of minimum benefits

The current system is unsatisfactory from the perspective of updating minimum benefit levels. Therefore, we recommend regular updates to the regulations based upon changes in the market environment. This should not merely be based upon a prescribed formula approach but taking cognisance of some general principles supported by reference to a defined index. One option, and that favoured by Vhi Healthcare is a two-pronged approach where benefit levels should be changed in accordance with some benchmark index factor annually and that the list of procedures to be contained within the minimum benefits should be reviewed based upon research on the needs of consumers, market practice and clinical advice on the significance of individual medical procedures (see below)[1].

The appropriate index to use is difficult to choose given that medical inflation in significantly different in nature and level to consumer price inflation or salary inflation. We recommend a mechanism be put in place such that cost information can be collected and collated each year for each minimum benefit procedures from all registered insurers and that this information is then used as a basis for the calculation of a relevant composite index using a weighted average approach.

[1] Only clinical proven treatments/technologies should form part of minimum benefits.

We have not outlined the precise technical details of such a calculation or process but we would be happy to provide suggestions later once the approach is accepted. Notwithstanding this, we believe that all insurers should agree the process and principles for the calculation process and that they should be clearly documented and coomuncated to the market.

3.4 Clinical expertise required to up-date minimum benefits

In terms of updating the listed benefits it is important that clinical input is made to choose what procedures should form part of minimum benefits. This would allow evaluations to be made of the necessity of adding new procedures, deleting obsolete procedures or even modifying procedures listed (e.g. to reduce cost as the procedure becomes cheaper to provide due to technical innovation).

Vhi Healthcare has an expert medical group in place, referred to as the Medical Advice Group, to advise our Medical Director on clinical issues including the benefits provided under our product range. The Group is comprised of experts in a wide range of medical fields. We recommend that a similar group be put in place to advise on changes to the minimum benefit regulations. The simplest and most cost effective method of doing this may be to establish a group comprised of nominated medical representatives of all registered insurers who could advise on the appropriate procedures for the minimum benefits. The group could also include a representative of the Chief Medical Officer of the Department of Health and Children.

3.5 Role of HIA

Given the nature of the work involved in reviewing the need for updating the minimum benefit regulations together with the resources involved in its completion it seems appropriate this is undertaken by those with some knowledge of the private health insurance market. In this regard, we support the idea that the HIA should carry out this

task. We consider that it is essential that a mechanism be put in place, such as enhanced powers to the HIA, which will allow changes to be made to the minimum benefit regulations annually.

Notwithstanding the method of updating regulations we believe that the minimum benefit regulations should be changed even before the HIA powers change given the importance of minimum benefits to the market.

4 Summary Recommendations

Geographic definition of minimum benefits

Minimum benefits should be established on a reasonable geographic basis to remove the possibility of abuse. However, in implementing this cognisance must be taken of the fact that not all treatments can be provided in all geographic locations.

Maximum claim excess levels

A maximum level of claim excess should be set out in the Minimum Benefit Regulations to discourage cherry picking and protect the consumer interest.

Ancillary health benefits

Minimum benefit regulation should not apply to ancillary health services, as defined in legislation.

Basis for setting minimum benefits

Minimum benefit regulations should continue to be structured in a similar manner to that now operating with perhaps some simplification in terms of the terminology used within the regulations.

Process for updating minimum benefits

Minimum benefit regulations should be updated annually based upon a review of the benefits types to be contained in the Regulations and the monetary level for minimum benefits applicable to those benefits.

Indexation of benefit limits

The monetary level for minimum benefits should be reviewed by reference to published indexes derived from data supplied by registered insurers within the market. The exact specification of the method for compilation of these indices should be clearly signalled to the insurers and agreed with them.

Establishment of Medical Advisory Group

To support the work in choosing the benefits that come under minimum benefits a Medical Advisory Group should be established with medical representatives from each of the registered undertakings.

Power to HIA to modify minimum benefits

Given its role within the market the HIA should manage the process for updating the minimum benefit regulations. We consider that it is essential that a mechanism be put in place, such as enhanced powers to the HIA, which will allow changes to be made to the minimum benefit regulations annually.

Immediate change in minimum benefits

Given the time period since the current version of the minimum benefits were introduced we recommend that they should be updated as soon as practicable.